

THE FEDERAL AVIATION ADMINISTRATION'S OVERSIGHT OF FALSIFIED AIRMAN MEDICAL CER- TIFICATE APPLICATIONS

(110-60)

HEARING
BEFORE THE
SUBCOMMITTEE ON
AVIATION
OF THE
COMMITTEE ON
TRANSPORTATION AND
INFRASTRUCTURE
HOUSE OF REPRESENTATIVES
ONE HUNDRED TENTH CONGRESS
FIRST SESSION

JULY 17, 2007

Printed for the use of the
Committee on Transportation and Infrastructure



U.S. GOVERNMENT PRINTING OFFICE

36-735 PDF

WASHINGTON : 2007

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U.S. House of Representatives
Committee on Transportation and Infrastructure
 Washington, DC 20515

James L. Oberstar
 Chairman

John L. Mica
 Ranking Republican Member

David Heymsfeld, Chief of Staff
 Ward W. McCarragher, Chief Counsel

July 17, 2007

James W. Coon II, Republican Chief of Staff

SUMMARY OF SUBJECT MATTER

TO: Members of the Subcommittee on Aviation

FROM: Committee on Transportation and Infrastructure, Oversight and Investigations Staff
 Subcommittee on Aviation

SUBJECT: Hearing on "FAA's Oversight of Falsified Airman Medical Certificate Applications"

PURPOSE OF THE HEARING

The purpose of this hearing is to examine the Federal Aviation Administration's oversight of the Airman Medical Certification process. Pilots who are physically or mentally unfit not only pose a danger to themselves and the flying public, they also jeopardize the lives and safety of anyone in their flight path.

The Federal Aviation Administration ("FAA") has established stringent criteria to determine whether airmen are medically fit to fly. In most cases, a medical condition would not preclude a pilot from obtaining a medical certificate, although the FAA requires these conditions to be disclosed and evaluated by Aviation Medical Examiners ("AMEs"). These criteria include a handful of "disqualifying" conditions which the Federal Air Surgeon has determined could compromise the ability of a pilot to safely operate an aircraft. Examples of disqualifying conditions include diabetes, heart replacement, neurological disorders, and mental illness.

While the FAA-required medical exams have some ability to detect disqualifying conditions, the exams rely heavily on self-reporting. Many conditions, including severe mental disorders, may not be readily apparent to an AME seeing a patient for the first time.

In July 2005, a Department of Transportation Inspector General ("IG") investigation uncovered "egregious cases" of airmen lying about debilitating medical conditions on their applications for Airman Medical Certificates. In a sample of 40,000 airman certificate-holders, the Inspector General found more than 3,200 airmen holding current medical certificates while simultaneously receiving Social Security benefits, including those for medically disabling conditions. While the U.S. Attorney's Office ultimately prosecuted more than 40 cases, the IG believes that hundreds more could have been pursued if the U.S. Attorney's resources had not been constrained. The cases involved pilots with a variety of medical conditions including schizophrenia and bipolar

disorder. The extent of the problem of falsified Airman Medical Certificate applications is unknown beyond the initial IG investigation.

As a result of this investigation, the Inspector General recommended that the FAA coordinate with the Social Security Administration and other providers of medical disability to identify individuals whose documented medical conditions are inconsistent with sworn statements made to the FAA. The IG also recommended that the application for an Airman Medical Certificate be amended to ask applicants whether they are currently receiving medical disability payments from any disability provider.

In 1987, an enforcement policy was implemented following an IG investigation of airmen's failure to disclose alcohol- or drug-related motor vehicle convictions on the Airman Medical Certificate application to address unintentional omissions that could incite FAA enforcement actions or criminal charges. The FAA instituted a 12-month amnesty period during which time airmen could correct any records without reprisal from FAA for falsifications of their applications. It did not, however, prevent the FAA from taking action in response to the disclosures, including revocation of pilot licenses when the circumstances warranted it.

The FAA's own researchers have documented hundreds of fatal accidents where pilots failed to disclose potentially disqualifying medical conditions on their Airman Medical Certificate applications. In a research study that analyzed the post-mortem toxicology reports in every fatal accident (386) during a ten-year period (1995-2005), the FAA research team found toxicology evidence of serious medical conditions in nearly 10 percent of pilots. Fewer than 10 percent of these medical conditions (or medications used to treat the conditions) were disclosed to the FAA. Furthermore, of the 386 pilots included in the FAA study, 38 percent (147) were rated for Air Transport or Cargo operations. Fifty-seven percent (219) were private or student pilots. Of the total number of pilots involved in fatal accidents, one-third (127) held first or second class medical certificates. These statistics imply that the falsification issue is not limited to recreational general aviation pilots.

Prior to each flight, pilots make decisions regarding their health and ability to safely operate their aircraft, regardless of their FAA medical status. FAR 61.53 requires a pilot who, "...knows ...of any medical condition that would make the person unable to meet the requirements for the medical certificate necessary for the pilot operation" to practice "self-grounding." Some argue that this system of self-certification before every flight has served the industry and the FAA very well and no efforts are needed on FAA's part to validate what airmen report on the formal application for an Airman Medical Certificate.

The hearing will address the Inspector General's recommendations, the FAA's response to these recommendations, the NTSB's activities related to accidents involving pilot medical incapacitation, and the views of the Aircraft Owners and Pilots Association ("AOPA") regarding the industry's perspective.

BACKGROUND

On March 19, 2007, a Committee staff report prepared for Chairman Oberstar was issued to the public. In a press conference on March 19, Chairman Oberstar also announced his intent to hold hearings on the issues raised in the report. The report is enclosed with this Summary of Subject Matter for reference purposes.

RECENT EXAMPLES OF PROSECUTIONS FOR AIRMAN MEDICAL CERTIFICATE FALSIFICATIONS

On March 28, 2007, a former aviation safety program manager in the FAA's Spokane, Washington Flight Standards District Office was fined \$1,000 and ordered to serve three years probation by a U.S. District Court judge for failing to report disqualifying prescription medications on his 2004 airman medical application. These prescriptions included Trazodone (a tranquilizer/antidepressant), Hydrocodone (a codeine derivative), and valium. The FAA considered this manager a "national resource" pilot for the Falcon jet because of his knowledge and expertise with this type of aircraft. The manager's duties included conducting proving flights for Falcon jet pilots approximately once a month, which the IG found he did while under the influence of the prohibited drugs.

On June 1, 2007, a Florida resident was ordered by a U.S. District Court judge to pay a \$1,000 fine and serve three years probation as a result of his conviction on charges of false statements on his applications for his 2002 and 2004 Airman Medical Certificates. The resident was a private pilot and had made false statements regarding his use of prescription medications. The pilot logged 177 hours of flight time while taking OxyContin, a narcotic pain reliever and prohibited medication. The individual stated that he was not taking any prescription drugs when, in fact, he was receiving workers compensation from the U.S. Postal Service and was taking prescription medications.

The FAA revoked both individuals' licenses.

WITNESSES

PANEL I

The Honorable Calvin L. Scovel, III
Inspector General
U.S. Department of Transportation
Washington, DC

Dr. Mitchell A. Garber, M.D., M.P.H., M.S.M.E.
Medical Officer
National Transportation Safety Board
Atlanta, GA

The Honorable Nicholas A. Sabatini
Associate Administrator for Aviation Safety
Federal Aviation Administration
Washington, DC

Accompanied by:

Dr. Frederick E. Tilton, M.D., M.P.H.
Federal Air Surgeon
Director, Office of Aerospace Medicine
Federal Aviation Administration
Washington, DC

PANEL II

Mr. Phil Boyer
President
Aircraft Owners and Pilots Association (AOPA)
Frederick, MD



Committee on Transportation and Infrastructure

FAA Oversight of Falsifications on Airman Medical Certificate Applications

Prepared for

*The Honorable James L. Oberstar
Chairman*

*By the Committee on Transportation and Infrastructure
Oversight and Investigations Majority Staff*

For Release on Delivery
11:00 a.m. EDT
March 27, 2007

FAA OVERSIGHT OF FALSIFICATIONS ON AIRMAN MEDICAL CERTIFICATE APPLICATIONS

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EXECUTIVE SUMMARY

Pilots that are physically or mentally unfit not only pose a danger to themselves and the flying public, they also jeopardize the lives and safety of anyone in their flight path.

The Federal Aviation Administration (FAA) has established stringent criteria to determine whether airmen are medically fit to fly. These criteria include a handful of “disqualifying” conditions which the Federal Air Surgeon has determined could compromise the ability of a pilot to safely operate an aircraft. Examples of disqualifying conditions include Diabetes, Angina, neurological disorders, and mental illness.

While the FAA-required medical exams have some ability to detect disqualifying conditions, the exams rely heavily on self-reporting. Many conditions—including severe mental disorders—may not be readily apparent to a doctor seeing a patient for the first time.

In July 2005, the Department of Transportation Inspector General found “egregious cases” of airmen lying about debilitating medical conditions on their applications for Airman Medical Certificates. In a sample of 40,000 Airman certificate-holders, the Inspector General found more than 3,200 airmen holding current medical certificates while simultaneously receiving Social Security benefits, including those for medically disabling conditions. While the U.S. Attorney’s Office ultimately prosecuted more than 40 cases, hundreds more could have been pursued if resources had not been constrained.

As a result of this investigation, the Inspector General recommended that FAA coordinate with Social Security and other providers of medical disability to identify individuals whose

documented medical conditions are inconsistent with sworn statements made to the FAA.

FAA’s own researchers have documented hundreds of fatal accidents where pilots failed to disclose potentially disqualifying medical conditions on their Airman Medical Certificate applications. The research team found toxicology evidence of serious medical conditions in nearly 10 percent of all pilots involved in fatal accidents during a ten-year period. Fewer than 10 percent of these medical conditions (or medications used to treat the conditions) were disclosed to FAA.

Despite these findings, FAA managers argue that the problem of airmen falsifying medical applications is negligible. In discussions with Committee staff, FAA acknowledged that it has no process to check for medically-related falsifications. FAA has not pursued the Inspector General’s recommendations because the Administration believes the project would be labor intensive and the safety risk would not justify the resources it would consume.

Committee staff find FAA’s response—to what is clearly a significant problem—unacceptable. We believe that FAA should pursue each of the Inspector General’s recommendations, including establishing a mechanism to periodically spot-check medical information provided to FAA on applications for Airman Medical Certificates. If nothing else, the knowledge that FAA is looking—and will follow through with swift and meaningful consequences if falsifications are found—should provide an incentive for airmen to be more forthcoming about their existing medical conditions.

BACKGROUND

On November 26, 1999, Itzhak Jacoby, his wife Gail, and their 13-year-old daughter, Atira, were returning to Washington D.C. after spending the Thanksgiving holiday in New York when the Beechcraft aircraft piloted by Mr. Jacoby slammed into a residential neighborhood in Newark, NJ, killing all three passengers and injuring 25 people on the ground—two of them critically. Eighteen buildings were damaged as the force of the impact knocked plaster off of the walls and ceilings in nearby apartment buildings, displacing 50 families.¹ Eleven cars were damaged or destroyed by fire. In all, the City of Newark estimated the property damage to exceed \$1.2 million.²

The autopsy of the pilot indicated the presence of a drug called “Fiorinal,” a treatment for acute migraines.³ The drug contains barbiturates, with common side effects of, “intoxication, hangover, tolerance, dependence, and toxicity.”⁴ Symptoms from Fiorinal intoxication include, “sluggishness, lack of coordination, difficulty thinking, poor memory, slowness of speech, and faulty judgment.”⁵

On Mr. Jacoby’s most recent FAA medical application – just one month before the accident – he stated affirmatively that he was not taking any prescription or nonprescription medication and stated affirmatively that he had never suffered from severe or frequent headaches.⁶

However, Mr. Jacoby’s personal medical records told a different story. Mr. Jacoby had been diagnosed with severe migraine headaches and between 1992 and 1999, Mr. Jacoby was prescribed more than 6,000 tablets of Fiorinal. The NTSB concluded that Mr. Jacoby’s medical condition was a causal factor in the accident.

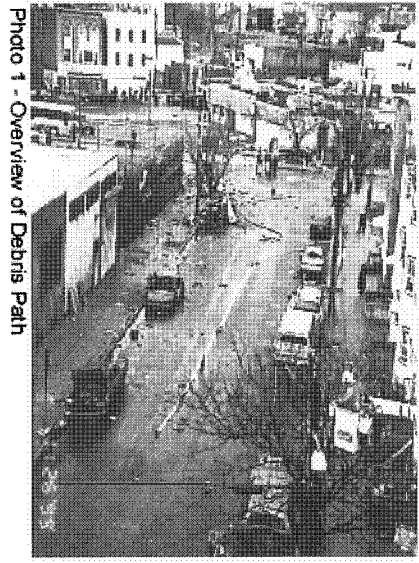


Photo courtesy of the National Transportation Safety Board

¹ Robert Hanley, *Problems Began Instantly in Fatal Newark Plane Crash*, New York Times (Dec. 1, 1999).

² National Transportation Safety Board Brief, NYC00FA039 (Nov. 26, 1999) (p. 1).

³ National Transportation Safety Board Factual Report – Aviation, NYC00FA039 Newark, NJ.

⁴ Dr. Stephen Silberstein and Dr. Douglas McCrory, *Headache: The Journal of Head and Face Pain* (Dec. 2001).

⁵ D.A. Ciraulo and D.J. Greenblatt, *Sedative-, Hypnotic-, or Anxiolytic-related disorders*, Comprehensive Textbook of Psychiatry, 6th ed. (1995) (pp. 872-875).

⁶ The Airman Medical Certificate is the critical prerequisite for obtaining and maintaining an active FAA pilot’s license.

FAA has attempted to prevent incidents such as this by establishing criteria which airmen must meet in order to be deemed medically fit to fly. In general, an airman must be free of any, “disease, defect, or limitation,” and any, “influence of medication or other treatment,” that could affect the ability to safely perform duties permitted by the airman certificate.⁷

FAA has defined the following conditions as “disqualifying,” meaning that an airman with these conditions or under pharmaceutical treatment for them will not be granted a medical certificate. Under limited circumstances, FAA may allow a pilot with these conditions to fly, but only under close supervision and with the assurance that the conditions are sufficiently under control as to ensure public safety.

Disqualifying conditions include:⁸

- Angina pectoris
- Bipolar disorder
- Cardiac valve replacement
- Coronary heart disease requiring treatment
- Diabetes mellitus, requiring insulin or other hypoglycemic medication
- Unexplained lack of consciousness
- Epilepsy
- Heart replacement
- Myocardial infarction
- Neurological disorders; epilepsy, seizures, stroke, paralysis, etc.
- Unexplained loss of nervous system functions
- Substance abuse and dependence
- Personality disorders
- Psychosis

Applicants for the Airman Medical Certificate are required to disclose these and any other medical conditions to FAA on their applications. Airmen must sign a waiver stating that all statements are, “complete and true to the best of [my] knowledge,” and are apprised that intentional falsification may result in, “federal criminal prosecution; suspension or revocation or denial of the application for medical certification.”⁹

⁷ 14 CFR part 67.213.

⁸ Ibid.

⁹ FAA Form 8500-8(3-99), *Instructions for the Completion of the Application for Airman Medical Certificate or Airman Medical and Student Pilot Certificate*.

PURPOSE, SCOPE AND METHODOLOGY

This report was compiled at the request of the Chairman of the Committee on Transportation and Infrastructure, James L. Oberstar. The findings include the results of two federally-funded studies. The first study, conducted jointly by the Department of Transportation-Office of Inspector General and the Social Security Administration-Office of Inspector General compared a sample of Airman Medical Certificates that were current during some part of the period between July 2003 and January 2005 and the records for individuals receiving Social Security medical disability benefits during that period. The second study, conducted by medical researchers at the FAA's Civil Aerospace Medical Institute in Oklahoma City, reviewed post-mortem toxicology reports for aviation accidents that occurred during the 10-year period 1993-2003. The methodology for each study is explained in detail within the source documents referenced in this report.

Committee staff also conducted meetings with and obtained information from the Association of Aviation Medical Examiners, researchers at the Civil Aerospace Medical Institute, staff from the National Transportation Safety Board, investigators from the Department of Transportation Inspector General's office, investigators and attorneys from the Social Security Administration Inspector General's office, and representatives from the U.S. Attorney's Office. This report also reflects data and information contained in a variety of studies, agency documents and reports, Government databases, court filings, media accounts, Federal statutes and regulation, and other source material which is annotated accordingly throughout this report. The Committee staff's work took place between January 15, 2007 and March 15, 2007. Additional copies of this report may be obtained from the Committee's website at <http://transportation.house.gov> or by contacting the Committee's communications office at 202-225-6260. Major contributors to this report include Leila Kahn, Senior Professional Staff, and Laurie Bertenthal, Staff Assistant.

FINDINGS

Inspector General Finds Pervasive Falsifications on FAA Airman Medical Certificate Applications

In July 2003, the Department of Transportation Inspector General launched an 18-month investigation into FAA's policing of the Airman Medical Certification process. Teaming up with the Social Security Inspector General on a project called "Operation Safe Pilot," the Inspector General compared the database of approximately 40,000 airmen holding current medical certificates in the northern region of California to the database of individuals receiving medical disability pay from the Social Security Administration.¹⁰

The presumption? If they're too sick to work, they're too sick to fly.

¹⁰ Aircraft Owners and Pilots Association, Regulatory Brief, *Operation Safe Pilot – Government Review of Certain FAA Pilot Medical Records to Investigate Social Security Fraud*.

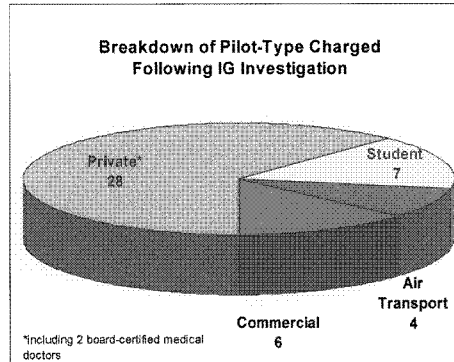
In July 2005, the IG identified “egregious cases” of pilots falsifying FAA’s Application for Airman Medical Certificates by not disclosing medical conditions for which they were receiving disability benefits.¹¹ These conditions included schizophrenia, bipolar disorder, cognitive disorder, degenerative disk disease, and obsessive-compulsive disorder. In all, the Inspector General found more than 3,200 airmen receiving Social Security benefits, including those for medically disabling conditions.

The investigation resulted in charges against 45 California residents for making false statements to FAA on their Airman Medical Certificate applications; specifically, concealing their disqualifying medical conditions in order to obtain and maintain their pilot certificates.¹² Included in those charged were an air ambulance helicopter pilot, a long-distance cargo pilot, and a corporate pilot flying Lear jets with passengers.

The number of individuals prosecuted as a result of this investigation was limited by both the resources available in the Inspector General’s Office and the U.S. Attorney’s office. With more resources, it is the staff’s opinion that hundreds of cases could potentially have been pursued. In addition, had the scope of the investigation included the universe of disability pay providers—Veteran’s Affairs, the U.S. Department of Labor, as well as state and locally administered pension funds—this number could easily reach into the thousands.

Pilots with Undisclosed Medical Conditions Pose Safety Dangers to Themselves and the Public

FAA’s own research indicates that airmen are concealing serious medical conditions; posing harm to themselves and the public. In November 2006, researchers from FAA’s Civil Aerospace Medical Institute¹³ published a study assessing post-mortem toxicology results for all 4,143 fatal aviation accidents in the 10-year period 1993-2003. The researchers found that 387 or nearly 10 percent of pilots involved in *fatal accidents* demonstrated evidence of either a neurological, mental, or



¹¹ U.S. Department of Transportation Office of Inspector General, *Falsification of FAA Airman Medical Certificate Applications by Disability Recipients* (July 22, 2005).

¹² United States Attorney Kevin V. Ryan, United States Department of Justice for Northern District of California, San Francisco, CA, Press Release: *40 Airplane Pilots Charged Across 5 Major California Cities in Criminal Air Traffic Safety Investigation Jointly Supervised by the United States Attorneys in Eastern and Northern District of California* (July 18, 2005).

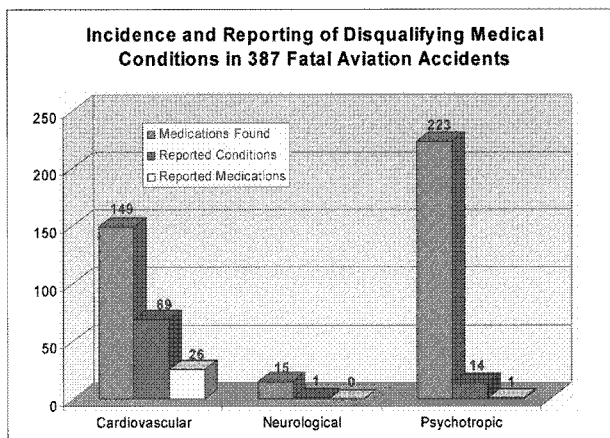
¹³ The Civil Aerospace Medical Institute (CAMI) is a research facility housed within FAA’s Office of Aerospace Medicine.

cardiovascular disorder¹⁴ that was not disclosed on their applications for an Airman Medical Certificate.¹⁵

The adjacent chart illustrates the breakdown by category of drugs tested in the study, and the degree to which either the condition itself or the medication used to treat the condition were disclosed to FAA.

The toxicology study focused on medications commonly used to treat conditions that are generally considered to be disqualifying—mental health, heart-related, and seizure-related

conditions. The researchers did not test for other categories of medications that might also indicate serious and/or disqualifying medical conditions, such as macular degeneration or vertigo.



FAA Has Failed to Develop an Effective Strategy to Identify Fraud

FAA has limited ability to identify false statements on Airman Medical Certificate applications. FAA has 45 examiners (none of whom are doctors) to process the approximately 450,000 applications each year; most applications that disclose no irregular medical conditions are simply filed without review and are approved at the recommendation of the submitting examiner. The exams themselves rely heavily upon self-reporting, and there are many conditions—including severe mental disorders—that may not be apparent to a new doctor during a 20 minute exam.¹⁶ Likewise, applicants must also disclose use of any medications to the examiner during the review.

Based on its findings in its 2005 investigation, the DOT Inspector General proposed a strategy to flag potential false statements on Airman Medical Certificate applications—comparing records from the population of individuals claiming benefits for medically-related disability to those claiming to be medically fit for the purpose of obtaining a pilot's license. The Inspector General made several recommendations to FAA in July 2005. Specifically, the Inspector General recommended that the FAA:

¹⁴ In most cases, FAA considers those disorders to be disqualifying medical conditions.

¹⁵ D.V. Canfield, G.J. Salar, R.J. Lewis, and J.E. Whinnery, *Pilot Medical History and Medications Found in Post Mortem Specimens for Aviation Accidents*, *Aviation, Space, and Environmental Medicine* (Nov. 2006) (Vol. 77, No. 11).

¹⁶ Summary of Committee Staff Meeting with Dr. Warren Silberman, Civil Aerospace Medical Institute (Feb. 28, 2007).

- Take steps to proactively identify and address falsifications throughout the greater community of certificated pilots. The Inspector General's review was limited to 40,000 Airman Medical Certificate-holders in northern California; a mere fraction of the approximately 650,000 foreign and domestic pilots holding current FAA Airman Medical Certificates.
- Work with Social Security and other disability benefits providers to expedite development and implementation of a strategy to carry out these checks and take appropriate enforcement action where falsifications are found. The Inspector General noted that FAA did not have any mechanism for identifying certificated pilots who were receiving medical disability benefits from any provider (DOL, Veterans Affairs, and Social Security).
- Revise its Application for Airman Medical Certificate to require applicants to explicitly identify whether they are receiving medical disability benefits from any provider.

The Inspector General advised that he would be, "pleased to assist FAA in exploring options for accomplishing this, to include database matching with record systems of the disability benefits providers, or, as an initial step, statistical random sampling."

In July 2005, when charges were initially brought against the 40 pilots by the U.S. Attorney's Office, FAA's Associate Administrator for Aviation Safety was quoted as saying, "The fraud and falsification allegedly committed by these individuals is extremely serious and adversely affects the public interest in air safety." Yet, nearly 2 years later, the Committee staff finds that FAA has made no effort to address the Inspector General's recommendations or to improve its oversight of falsifications on applications for Airman Medical Certificates.

At the request of Committee staff in January 2007, the Inspector General inquired about the status of the recommendations. FAA staff in the Office of Safety replied that coordinating with Social Security and other Agencies that provide disability benefits would be a, "very labor intensive process," and indicated that, "we were not able to make the safety case that this would be the best way to use our resources in the Office of Aerospace Medicine."¹⁷ In subsequent meetings and correspondence between Committee staff and FAA; the Federal Air Surgeon, the Deputy Associate Administrator for Aviation Safety, and the Assistant Chief Counsel for Enforcement reiterated their beliefs that the magnitude of the problem was not sufficient to warrant implementing the Inspector General's recommendations and that doing so would not be an effective use of FAA's resources.

By its own inexplicable calculations, FAA estimates that these recommendations would prevent just two fatalities a year. This argument makes a mockery of FAA's safety regulations. FAA has the strictest medical fitness requirements in the world because it knows—and has stated publicly—that medically unfit pilots pose a real danger to themselves and the public.

When questioned, FAA admitted that it had not made any overtures to the Social Security Administration or to the DOT Office of Inspector General, as recommended, to assess the feasibility—both logistically and legally—of developing a process to flag potential false statements made by airmen during the certificate application process.

¹⁷ Email correspondence between Peggy Gilligan, FAA Office of Safety, to Rick Beitel, DOT Office of Inspector General; Subject: *Re: FW: Follow-up on OIG Recs; Re: Airman Med. Form Falsification* (Feb. 5, 2007).

CONCLUSION

The Committee staff finds FAA's response to the danger posed by airmen lying about their medical conditions unacceptable. Contrary to FAA's opinion that the problem is not widespread and therefore not worthy of the resources it might take to identify and penalize the wrongdoers, the Social Security matching study conducted by the Inspector General as well as the toxicology study performed by FAA scientists suggest that the practice is rampant. In fact, even if the 45 individuals prosecuted from the sample of 40,000 airmen in Northern California were the *only* individuals found to be lying on their Airman Medical Certificate applications—and we know that this *far* understates the extent of the problem—extrapolated to the universe of individuals holding current Airman Medical Certificates, the number would approach 1,000. Extrapolating the nearly 10 percent found by FAA researchers in the post-mortem toxicology study, that number would approach 64,000.

Because FAA does not consider these false disclosures to be a problem, it has not established any mechanism to verify the medical information reported to FAA, even on a “spot-check” basis. In fact, the current medical oversight process actually penalizes those airmen who *do* tell the truth. FAA simply files away a “clean” medical report without any review, whereas medical reports with potentially disqualifying conditions receive extensive scrutiny from the Federal Air Surgeon's office. The consequences of disclosing medical conditions include potentially being denied a certificate, which in essence grounds that pilot. There are *no* consequences for *not* disclosing this information. FAA cannot punish non-compliance if it does not attempt to look for it.

The Committee staff recommends that FAA pursue the Inspector General's recommendations, including establishing a strategy to coordinate with providers of disability benefits to periodically sample and verify medical information provided on Airman Medical Certificate applications. If nothing else, the knowledge that FAA is spot-checking disclosures—and that swift and meaningful consequences will follow if falsifications are found—should provide a powerful incentive for applicants to be more forthcoming on their applications for Airman Medical Certificates.

Appendix 1: Most Common Toxicology Results Found in Post-Mortem Testing of Pilots Involved in Fatal Accidents, 1993-2003¹⁸

# Found	Drug	Common Name	Common Uses	Common Side Effects
40	Fluoxetine	Prozac, Sarafem	Selective serotonin reuptake inhibitor (SSRI) used to treat depression, obsessive-compulsive disorder, panic attacks, certain eating disorders (bulimia), and a severe form of premenstrual syndrome.	Nausea, loss of appetite, diarrhea, dry mouth, trouble sleeping, dizziness, drowsiness, yawning, weakness, or sweating may occur.
33	Atenolol	Tenormin	Beta-blocker used to treat chest pain (angina) and high blood pressure. It is also used after an acute heart attack to improve survival.	Dizziness, lightheadedness, drowsiness, tiredness, nausea, diarrhea, unusual dreams, leg pain, or vision problems.
33	Verapamil	Calan, Isoptin	Used with or without other medications to treat high blood pressure (hypertension), chest pain (angina) and certain types of irregular heartbeat.	Dizziness, nausea, headache, fatigue.
29	Diazepam	Valium	Used to treat anxiety, acute alcohol withdrawal, and seizures. It is also used to relieve muscle spasms and to provide sedation before medical procedures.	Drowsiness, dizziness, fatigue, constipation, blurred vision, or headache.
26	Sertraline	Zoloft	Selective serotonin reuptake inhibitor (SSRI) used to treat depression, panic attacks, obsessive compulsive disorders, post-traumatic stress disorder, and social anxiety disorder (social phobia).	Nausea, dizziness, dry mouth, loss of appetite, increased sweating, drowsiness, diarrhea, upset stomach, or trouble sleeping.
24	Metoprolol	Toprol	Beta-blocker used to treat chest pain (angina), heart failure, and high blood pressure.	Dizziness, lightheadedness, drowsiness, tiredness, diarrhea, unusual dreams, trouble sleeping, or vision problems.
23	Diltiazem	Cardizem	Used with or without other medications to treat high blood pressure (hypertension) and chest pain (angina).	Dizziness, drowsiness, fatigue, nausea and headache; unlikely but serious side effects occur: swelling of the ankles/feet, shortness of breath, persistent fatigue, fast/irregular/very slow heartbeat, unusual dreams, mental/mood changes, and fainting.
21	Paroxetine	Paxil	Selective serotonin reuptake inhibitor (SSRI) used to treat depression, panic attacks, and social anxiety disorder (social phobia).	Nausea, vomiting, drowsiness, dizziness, diarrhea, trouble sleeping, yawning, constipation, or dry mouth may occur.

¹⁸ All information from this table is taken from the website WebMD (online at <http://www.webmd.com>).

# Found	Drug	Common Name	Common Uses	Common Side Effects
16	Nordiazepam	Relative of Valium	Used to treat anxiety, acute alcohol withdrawal, and seizures. It is also used to relieve muscle spasms and to provide sedation before medical procedures.	Drowsiness, dizziness, fatigue, constipation, blurred vision, or headache.
14	Bupropion	Wellbutrin	Used to treat depression and to treat attention deficit hyperactivity disorder (ADHD). This drug may also be used with other medications to treat bipolar disorder (depressive phase).	Nausea, vomiting, dry mouth, headache, constipation, increased sweating, joint aches, sore throat, blurred vision, strange taste in the mouth, or dizziness. May also cause chest pain, fainting, fast/pounding/irregular heartbeat, hearing problems, ringing in the ears, severe headache, mental/mood changes (e.g., agitation, anxiety, confusion, hallucinations), and uncontrolled movements (tremor).
13	Citalopram	Celexa	A selective serotonin reuptake inhibitor or SSRI used in the treatment of depression and other mental conditions (obsessive-compulsive disorder, panic disorder).	Nausea, vomiting, lack of appetite, diarrhea, drowsiness, dizziness, trouble sleeping, dry mouth, muscle/joint pain, fatigue, or yawning.
11	Phenytoin	Dilantin	Used to prevent and control seizures (also called an anticonvulsant or antiepileptic drug).	Headache, nausea, vomiting, constipation, dizziness, drowsiness, trouble sleeping, or nervousness.
10	Amitriptyline		Used to treat depression and other mental/mood problems (e.g., anxiety, bipolar disorder), certain types of pain (e.g., peripheral neuropathy, neuropathic pain), eating disorders (e.g., bulimia), and trouble sleeping, or to prevent migraine headache.	Drowsiness, dizziness, dry mouth, blurred vision, constipation, fast heartbeat, nausea, vomiting, loss of appetite, changes in taste, weight gain, tiredness, or trouble urinating. Other less common side effects may include, confusion, mental/mood changes (e.g., agitation, excitement), loss of coordination, shaking, restlessness, uncontrollable movements of the mouth/face/hands, fast/irregular heartbeat, numbness/tingling of the hands/feet, ringing in the ears, nervousness, and shakiness.
10	Imipramine	Tofranil	Used for the treatment of depression, anxiety, panic disorders, and certain types of ongoing pain.	Dry mouth, blurred vision, headache, drowsiness, dizziness, constipation, nausea, vomiting, loss of appetite, diarrhea, stomach cramps, weight gain/loss, and increased sweating.

Appendix 2: Examples of Aviation Accidents and Incidents Involving Pilots With Medical Conditions not Disclosed on FAA Airman Medical Certificate

March 31, 2006
Double Springs, AL
Serious Injury

In March 2006, a 77-year old pilot sustained serious injuries after colliding with trees in Double Springs, Alabama. His flight originated in Clarksdale, Mississippi where employees noticed strange behavior. The pilot exited the plane without turning off the master switch and stated, “You know I’ve been flying for 60 years, and don’t tell anybody, but I’m lost.” After purchasing a map, he took off again, first heading northeast, then turning back towards the northwest, and finally crashing into the trees. When a few locals approached him, he said that he had been in a vehicle accident. He later revealed that he had been diagnosed by his private physician with dementia about 6 to 8 years earlier but never disclosed it to the Aviation Medical Examiner. On his third-class medical certificate, the only restriction listed was, “must wear corrective lenses.”¹⁹

July 13, 2001
Cartersville, MO
Total fatalities: 6

On July 31, 2001, the 70-year old pilot of a twin-engine airplane carrying 5 passengers crashed into a house in upper-scale residential area in Cartersville, MO, killing the pilot and all five of his passengers. The passengers included the two owners of the aircraft, the pilot’s two stepdaughters, and his son-in-law. The group was going to Joplin, MS to visit another family member.²⁰

The pilot’s autopsy revealed two volatile concentrations of antihypertensive cardiovascular drugs that were not disclosed on his medical exam. Additionally, Theophylline, a drug which treats severe cases of bronchial asthma was detected in the pilot’s blood. The pilot had undergone coronary bypass surgery in 1998, but was medically recertified in 1999. He had a second-class medical certificate from just a month prior to the incident that only stated visual limitations for which he required glasses. None of his medications were disclosed.²¹

¹⁹ National Transportation Safety Board, *Factual Report Aviation ATL06LA058* (Mar. 31, 2006) (online at <http://www.nts.gov/ntsb/GenPDF.asp?id=ATL06LA058&rpt=fa>).

²⁰ Connie Farrow, *Six Killed in Southwest Missouri Plane Crash*, Lawrence Journal-World (July 13, 2001) (online at http://www2.ljworld.com/news/2001/jul/13/six_killed_in/).

²¹ National Transportation Safety Board, *Accident Reports CHI01FA206* (July 13, 2001) (online at <http://www.nts.gov/ntsb/GenPDF.asp?id=CHI01FA206&rpt=fa>).

November 17, 1996
Eagle, CO
Total fatalities: 5

On November 17, 1996 a pilot collided with a wooded ridge in Eagle, CO, where it burned, killing the pilot and four passengers. Although the pilot stated on his most recent Airman Medical Certificate that he did not have any mental disorders, depression, anxiety, substance dependence or substance abuse; psychiatric records indicate the pilot had a history of mood instability, adolescent conduct disorder, drug and alcohol abuse, and two suicide attempts. Shortly after the pilot began flying in 1996, his psychiatrist recommended that he discontinue flying, withdraw from amphetamines, and take Lithium.²² At the time of his death, the pilot was taking several drugs commonly used to treat depression and an addictive opiate commonly prescribed for pain. Both classes of drugs are contraindicated for flying.

August 31, 2003
Kingsport, TN
Total Fatalities: 2

In August 2003, a private flight instructor and his student collided with the ground about three miles from the Tri Cities Regional Airport. Sertaline, a psychotropic drug which treats depressive disorders was detected in the instructor's blood and liver. Metoprolol, a cardiovascular drug prescribed for high blood pressure, was present in the student pilot's system at the time. The flight instructor involved in the crash held a first-class medical certificate issued in March 2003 with no limitations; and the student pilot had a third-class medical issued in April 2003 with only visual limitations listed for which he had to wear glasses.²³

²² National Transportation Safety Board, *Accident Reports FTW97FA042* (Nov. 19, 1996) (online at <http://www.nts.gov/ntsb/GenPDF.asp?id=FTW97FA042&crpt=fa>).

²³ National Transportation Safety Board, *Accident Reports ATL03FA134* (Aug. 31, 2003) (online at <http://www.nts.gov/ntsb/GenPDF.asp?id=ATL03FA134&crpt=fa>).

HEARING ON FAA'S OVERSIGHT OF FALSIFIED AIRMAN MEDICAL CERTIFICATE APPLICATIONS

Tuesday, July 17, 2007

HOUSE OF REPRESENTATIVES
COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE,
SUBCOMMITTEE ON AVIATION,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:00 a.m., in Room 2253, Rayburn House Office Building, the Honorable Jerry F. Costello [Chairman of the Subcommittee] presiding.

Mr. COSTELLO. The Subcommittee will come to order. The Chair will ask all Members, staff, and everyone to turn their electronic devices off or on vibrate.

The Subcommittee is meeting today to hear testimony on the FAA's oversight of falsified Airman Medical Certificate applications.

The Chair will give a brief statement, recognize Mr. Petri, the Ranking Member, and any other Member that wants to make a statement, and then we will introduce our witnesses today.

I welcome everyone here today to this hearing on the FAA's oversight of falsified Airman Medical Certificate applications.

In July 2005, the Department of Transportation's Inspector General found egregious cases of pilots failing to disclose debilitating medical conditions on their applications for Airman Medical Certificates. The U.S. Attorney's Office prosecuted more than 40 cases, but hundreds more could have been pursued if adequate resources had been available. The Department of Transportation Inspector General made three recommendations in that report, and the FAA is actively pursuing those recommendations.

In April 2007, the FAA began working to implement a strategy and system to coordinate with the Social Security Administration to verify information on Airman Medical Certificate applications. Further, the FAA is revising its application form to explicitly ask the applicant if they are receiving medical disability benefits. Both are important changes, and I am interested in hearing more from Mr. Sabatini and Mr. Scovel on this development.

The FAA has some of the strictest medical requirements in the world. By taking the necessary steps to improve the process, by establishing a way to verify medical information reported to the FAA, we can continue to ensure the safety of the pilot and the flying public.

I am also pleased that Mr. Boyer, Phil Boyer, is here today to testify from AOPA. AOPA is the largest civil aviation organization in the world, and they have developed a four-point plan of action to educate pilots to address this problem. I am interested in hearing more about the plan from Mr. Boyer when he testifies.

I have repeatedly said that, while the United States has the safest air transportation system in the world, we cannot rely on or be satisfied with our past success. We must work together to ensure the highest level of safety for the traveling public.

Before I recognize Mr. Petri for his comments or opening statement, I ask unanimous consent to allow two weeks for all Members to revise and extend their remarks, and to permit the submission of additional statements and materials by Members and witnesses. Without objection, so ordered.

At this time, the Chair recognizes the Ranking Member, Mr. Petri.

Mr. PETRI. Thank you very much, Mr. Chairman. I would like to join you in welcoming the witnesses this morning and saying that I look forward to learning more about the Department of Transportation's Office of the Inspector General investigation into falsified FAA Airman Medical Certificate applications. I guess they are called Operation Safe Pilot.

The vast majority of pilots are law-abiding citizens. However, the Inspector General's investigation indicates that, whether knowingly or not, some pilots have made false statements on their Airman Medical Certificate applications. These applications are used to evaluate a pilot's physical and mental fitness to fly.

Of the 40,000 pilot samples considered in Operation Safe Pilot, the Inspector General prosecuted 45 of the most egregious cases, ultimately resulting in criminal penalties and the revocation of pilots' licenses. Forty-five pilots whose cases were brought to prosecution were receiving Social Security Administration medical disability benefits for disqualifying conditions without reporting those medical conditions on the application for a medical certificate.

There may have been more criminal cases, but resource limitations prevented the U.S. Attorney's Office and the Inspector General from expanding the investigation.

It is important to note that the true nature of the problem is still not clear. Regardless, I look forward to hearing from our panelists on how we can address these issues in a manner that is appropriate to the level of risk these types of omissions pose to the safety of the system and to the public on the ground.

It is my understanding that the FAA is considering a revision to the application for the Airman Medical Certificate. Changes to the application will make questions clearer so that a pilot could not justify an omission based on the wording of a question. I am interested to hear the progress on this effort, as well as an estimate of the cost of reviewing and evaluating medical conditions.

About 20 years ago, the FAA offered a brief amnesty period to allow both commercial and recreational fliers the opportunity to come forward and report ailments without being subjected to criminal penalties for the omission. I am interested in hearing from our panel as to whether allowing another brief amnesty period would make sense.

Amnesty only works when there is some threat of enforcement after the amnesty period closes. Given the resources available in the budget, would it be possible for the FAA to audit all of the 600,000 commercial and recreational pilot applications, or would such action divert resources away from higher risk safety initiatives? Perhaps the FAA could audit a percentage of the applications each year. That way there is always the risk that, if you falsify, you could get caught. It works for the IRS. Why not FAA?

In any event, I would like to thank our witnesses for participating in today's hearing, both our government witnesses and one of the user groups, the Aircraft Owners and Pilots Association. AOPA is one of our great partners in the effort to keep the skies safe, and I appreciate their participation in today's hearing.

With that, I yield back the balance of my time.

Mr. COSTELLO. The Chair thanks the Ranking Member and, at this time, would first welcome our witnesses and thank you all for being here today. Let me introduce our first panel.

First, the Honorable Calvin Scovel III, who is the Inspector General for the U.S. Department of Transportation, who has testified before this Subcommittee many times and who shared tenure as the IG; Dr. Mitchell Garber, who is the Medical Officer for the National Transportation Safety Board; the Honorable Nicholas Sabatini, who is the Associate Administrator for Aviation Safety with the FAA, and Mr. Sabatini has testified many times before the Subcommittee; and Dr. Frederick Tilton, who is the Federal Air Surgeon for the Director of the Office of Aerospace Medicine with the FAA, who is accompanying Mr. Sabatini here this morning.

The Chair, at this time, would recognize Mr. Scovel for your testimony.

TESTIMONY OF THE HONORABLE CALVIN L. SCOVEL III, INSPECTOR GENERAL, U.S. DEPARTMENT OF TRANSPORTATION; MITCHELL A. GARBER, M.D., M.P.H., M.S.M.E., MEDICAL OFFICER, NATIONAL TRANSPORTATION SAFETY BOARD; THE HONORABLE NICHOLAS A. SABATINI, ASSOCIATE ADMINISTRATOR FOR AVIATION SAFETY, FEDERAL AVIATION ADMINISTRATION, ACCOMPANIED BY FREDERICK E. TILTON, M.D., M.P.H., FEDERAL AIR SURGEON, DIRECTOR, OFFICE OF AEROSPACE MEDICINE, FEDERAL AVIATION ADMINISTRATION

Mr. SCOVEL. Mr. Chairman, Ranking Member Petri, Members of the Subcommittee, we appreciate the opportunity to testify today regarding falsification of the FAA's application for Airman Medical Certificate. Our testimony today is primarily based on an investigation called Operation Safe Pilot, which we conducted with the Social Security Administration's Office of Inspector General and U.S. Attorney Offices in California. The investigation focused on pilots who represented to FAA that they were medically fit to fly, while at the same time claiming medical disability benefits.

Today, Mr. Chairman, I would like to discuss three key points, as we see them, for mitigating the safety risks posed by airmen who falsify their Airman Medical Certificate applications.

First, it is important to recognize that the Airman Medical Certification Program is an essential safeguard to ensure that pilots

are medically fit to fly. FAA requires that each pilot have a valid medical certificate before being allowed to operate an aircraft. To receive a medical certificate, pilots must complete an Airman Medical Certificate application and be examined by an FAA-designated Aviation Medical Examiner. Those who meet the appropriate medical standards based on an in-person medical examination and an evaluation of medical history are issued a medical certificate. As of June 2007, FAA's database showed there were over 625,000 pilots with current Airman Medical Certificates.

The Federal Air Surgeon has identified certain medical conditions that specifically disqualify an individual from receiving a medical certificate because those conditions could compromise a pilot's ability to safely operate an aircraft. These conditions include neurological and psychiatric disorders.

Second, our investigation, Operation Safe Pilot, disclosed a potential systemic problem regarding falsification of medical certificates that requires greater attention and oversight by FAA. In 2003, our office initiated Operation Safe Pilot to determine whether a scheme uncovered in 2002 reflected a systemic problem. In the 2002 case, we determined that a pilot in California had defrauded both FAA and Social Security by making false statements to doctors for the purpose of maintaining his FAA private pilot certificate while obtaining Social Security benefits. For approximately 14 years, this pilot had used two different doctors, one to conclude that he was in good physical health in order to maintain his Airman Medical Certificate, and one to diagnose him with a disabling disease in order to fraudulently receive Social Security benefits. He was ultimately convicted of fraud and sentenced to serve a 21 month prison term and pay nearly \$200,000 in restitution.

Operation Safe Pilot began with a universe of about 40,000 pilots residing in Northern California. We focused our investigative efforts on a smaller group of 48 pilots who were receiving Social Security disability benefits. At our request, the FAA Regional Flight Surgeon reviewed case files for those pilots and determined they would not have passed the airman medical examination had the examining physicians known about the pilots' disqualifying medical conditions.

The U.S. Attorney's Office initiated criminal prosecutions against all 48 pilots, 45 of whom were convicted of making false statements to FAA. In all 48 cases the pilots failed to notify FAA about their well documented, severe, pre-existing medical conditions. Many of those pilots had multiple disqualifying conditions, with the most common condition being some type of mental disorder such as schizophrenia.

In addition to Operation Safe Pilot, both the NTSB and FAA have published reports showing that pilots often did not disclose serious medical conditions which sometimes resulted in accidents and fatalities. For example, a May 2006 FAA research report of post-mortem toxicology for 4,143 pilots who died in aviation accidents between 1993 and 2003 found that nearly 10 percent were taking some type of psychotropic, cardiovascular, or neurological medication not reported on their Airman Medical Certificate applications. The report's authors essentially concluded that pilots who took certain types of medications and were involved in fatal acci-

dents rarely reported those medications and their underlying medical conditions to FAA.

Third, FAA can take several actions to ensure that disabled pilots do not circumvent the medical certification process. In July 2005, we sent a memorandum to the DOT Secretary and FAA Administrator highlighting the results of Operation Safe Pilot. We pointed out that FAA did not have a mechanism for identifying certificated pilots who were receiving medical disability benefits. We recommended that FAA work with the Social Security Administration and other Federal disability providers to, one, develop and implement appropriate checks and take enforcement actions; and, two, consider revising its application for Airman Medical Certificates to require applicants to explicitly identify whether they are receiving medical disability benefits.

In April 2007, FAA initiated discussions with Social Security to match the FAA database of pilots against relevant Social Security databases. Both agencies have been discussing how such a process could be structured under the Privacy Act to ensure compliance with law. FAA has also expressed its intention to revise the application for Airman Medical Certificate to explicitly ask about the receipt of medical disability benefits.

These are appropriate first steps. In our opinion, FAA should also consider two additional measures: one, conduct an education and outreach effort to ensure pilots are fully aware of their responsibilities for accurately disclosing their medical histories on the Airman Medical Certificate application; and, two, offering a grace period to pilots who self-identify previously undisclosed medical conditions. FAA, however, would need to make it absolutely clear that all medical conditions disclosed would be evaluated and, unless pilots were found at that time to be medically fit to fly, their Airman Medical Certificates would be subject to revocation.

That concludes my statement, Mr. Chairman. I would be pleased to address any questions you or other Members of the Subcommittee may have.

Mr. COSTELLO. The Chair thanks you and recognizes Dr. Garber for his testimony.

Dr. GARBER. Good morning, Chairman Costello, Chairman Oberstar, Ranking Member Petri, and Members of the Subcommittee. Thank you for allowing me the opportunity to present testimony on behalf of the National Transportation Safety Board regarding Federal Aviation Administration's oversight of falsified Airman Medical Certificate applications. It is a privilege to represent an agency that is dedicated to the safety of the traveling public.

On June 17th, 2002, an aircraft operated by a commercial-rated pilot performing wolf survey flights under contract to the Michigan Department of Natural Resources descended at high speed into terrain. The pilot and his personal physician, who later became his aviation medical examiner for many years, had concealed from the FAA information regarding the pilot's multiple, serious medical conditions on seven applications for Airman Medical Certificates. The pilot's physician had denied knowing the pilot when the FAA was investigating a report that the physician was treating him for these conditions.

At the time of the accident, the pilot's physician had been decertified as an aviation medical examiner for failure to complete required training, and the pilot did not have a current medical certificate, having been deferred for certification by a new aviation medical examiner who noted some abnormal heart rhythms on examination. The Safety Board concluded that the accident was caused by the incapacitation of the pilot and that a contributing factor was the pilot and his physician providing false information on the pilot's medical applications.

A recent staff review of over 20,000 aviation accidents investigated since 1995 found 327 in which impairment, incapacitation, or a medical condition were identified as causes or factors. Medications and substances of abuse were each found in over 100 of these cases. In 26 of these cases, it was determined that a pilot with a current medical certificate and a known medical condition had information regarding that condition that was not revealed to the FAA at the time of the most recent application for medical certificate.

It is important to note that these numbers are certainly an underestimate of the extent to which this issue is involved in accidents. In many cases, there is insufficient evidence available to completely evaluate the possibility of impairment or incapacitation.

The Safety Board is fortunate to benefit from the resources of the FAA Toxicology Laboratory at the Civil Airspace Medical Institute, likely the finest toxicology laboratory in the world for analysis of specimens for accident investigations. We are, therefore, often able to determine that a pilot used a specific substance in the hours or days preceding the accident, most frequently a substance that was not reported to the FAA.

The Safety Board has been concerned for many years regarding the inappropriate use of certain medications by pilots and other vehicle operators and, in 2000, issued comprehensive recommendations on this topic to the Department of Transportation, the Food and Drug Administration, and modal agencies to improve information provided to such operators regarding the use of appropriate medications while engaged in vehicle operations. Although some modal agencies have taken responsive actions, the overall response to date from the DOT and the FAA has been limited, and the majority of the recommendations on this topic have not been implemented.

The Safety Board has also noted that, with many accidents due to a pilot's intoxication by alcohol, illicit substances, or large amounts of potentially addictive medications, the FAA was or should have been aware of information that would have led them to conclude that the pilot was substance dependent and would have restricted issuance of a medical certificate. In particular, the Board has noted a number of instances in which the FAA did not request details of an identified DUI conviction in order to determine the circumstance of that violation.

Additionally, the Board has found that the information available to the FAA on potentially substance-dependent pilots was often not provided to individuals evaluating the pilots for possible substance dependence. Furthermore, the Board is concerned that, unlike other chronic conditions, the FAA does not now routinely require

that pilots with substance dependence be followed for the condition for the period that they hold their medical certificate. The Board has recently issued several recommendations to address these deficiencies.

Finally, the Safety Board notes that, unlike many other countries, and inconsistent with the International Civil Aviation Organization recommendations, there is no requirement for the reporting of medical conditions in between periodic examinations. This significantly increases the complexity of establishing that a condition was concealed from the FAA, since it may not have become apparent until after the most recent medical examination. The FAA has recently proposed increasing the interval between medical examinations for certain pilots and the Safety Board has noted in its comments to that NPRM that a reporting requirement in between examinations would be desirable.

This concludes my prepared statement, and I would be happy to answer any questions.

Mr. COSTELLO. Thank you, Dr. Garber.

The Chair recognizes Mr. Sabatini.

Mr. SABATINI. Good morning, Chairman Costello, Chairman Oberstar, Congressman Petri, and Members of the Subcommittee. I am pleased to appear before you today to discuss the Federal Aviation Administration's oversight of the Airman Medical Certification application process.

Let me assure you that the FAA takes this matter seriously, and we are very concerned about any falsification of information on Airman Medical applications. Let me also say that the vast majority of our nation's pilots are honest, dedicated, and have contributed significantly to our current unprecedented safety record.

FAA agrees with the recommendations of the Inspector General on falsified Airman Medical applications, and we are taking steps to implement those recommendations, as I will discuss. We are also taking other proactive steps regarding this issue, which I will also discuss.

As you are aware, the Department of Transportation Inspector General issued a report in 2005 describing the results of an investigation known as Operation Safe Pilot. I will not spend time discussing the details of the IG's findings; they are already well known to you. However, I will discuss the IG's recommendations and the FAA's response to those recommendations.

The Inspector General recommended that FAA work with the Social Security Administration and other disability benefits providers to develop and implement a strategy to conduct checks of applicants for Airman Medical Certificates with the databases of those disability benefits providers and take appropriate enforcement actions where falsifications are found. The IG also recommended that FAA consider revising our application for Airman Medical Certificate to require applicants to explicitly identify whether they are receiving medical disability benefits from any provider.

I am pleased to inform you that the FAA is moving forward to implement both of the IG's recommendations. FAA is working to develop a program in cooperation with the Office of the Inspector General for the Social Security Administration to cross-check randomly selected applicants for FAA Airman Medical Certificates

with the Social Security disability database to determine if any applicants are receiving disability from the Social Security Administration.

I must emphasize that we are still working with the Social Security Administration's IG's Office and the Social Security Administration itself to determine what information they are willing to grant us access to and then develop a framework for how such checks will be conducted. We hope to start by cross-checking applicants to the Social Security Administration databases because, to receive Social Security disability benefits, an individual must be totally disabled. Thus, virtually any applicant who is receiving Social Security Administration disability benefits will necessarily have a condition that would disqualify the applicant from holding an Airman Medical Certificate from the FAA.

While it is premature to discuss any future expansion of the cross-checking of applicants to disability databases other than the Social Security Administration, we would have to carefully consider the potential resources required to conduct investigations and make medical determinations regarding an applicant's disability and whether that condition disqualifies the applicant from holding an Airman Medical Certificate before taking such a step.

In order to proceed with cross-checking applicants for Airman Medical Certificates against the Social Security Administration disability database or any other database, FAA must first make a change in the policy allowing routine use of private information. This will require publishing a notice of the proposed change in the Federal Register and a comment period before the change can be implemented and FAA could begin any cross-checking. This process might take six to twelve months to complete.

However, we will immediately begin efforts to implement the IG's second recommendation, the addition of a question to the Airman Medical Certificate application regarding disability benefits. The FAA will propose to OMB the change to the application form to include the question. Upon approval from OMB, the new application form can be printed and distributed to Airman Medical Examiners nationwide.

We are proposing to change the Airman Medical Certificate application to add a question specifically asking if the applicant is receiving any disability benefits. While this additional question appears straightforward, the investigative work will begin after a positive response to the question. Once an applicant indicates he or she is receiving disability benefits, FAA would then have to investigate to determine the disability benefits provider, the condition for which the applicant is receiving disability benefits, and the extent of the applicant's disability.

FAA is also being proactive in other areas regarding falsification of data on Airman Medical Certificate applications. The FAA Civil Aerospace Medical Institute has now developed an integrated scientific information system that will provide a continuous monitoring of all Airman Medical Certification records compared to aviation accidents or incidents and post-mortem toxicology reports.

The FAA will, therefore, have the capability of continuously monitoring any aircraft accidents and accessing any discrepancy between the information on the certificate and any post-mortem find-

ings. This includes prescription and non-prescription medications and medical abnormalities that could affect the ability to safely perform duties permitted by the Airman Certificate and which are related to the National Transportation Safety Board causal accident factors.

In 2006, the FAA's Office of Aerospace Medicine initiated a routine process analysis study to evaluate and improve the efficiency of airman medical certification within the FAA. The Airman Medical Examiner Airman Certification Quality Assurance Study evaluates the accuracy of AMEs in determining the suitability of Airman Medical certification. It is another tool that will assist the FAA in monitoring this issue. We are committed to expanding our efforts to review medical certificates and pursue appropriate enforcement actions when falsifications are discovered.

Let me conclude, Mr. Chairman, by stating that the FAA's first priority always has been and always will be safety. Safety is our agency's mission, and we have dedicated our careers to promoting safety. It is a responsibility we do not take lightly.

This concludes my statement, and I would be happy to answer any questions the Committee may have.

Mr. COSTELLO. The Chair thanks you, Mr. Sabatini.

At this time, the Chair recognizes the distinguished Chairman of the Full Committee, Chairman Oberstar.

Mr. OBERSTAR. Thank you, Mr. Chairman, for holding the hearing; and, Mr. Petri, for your participation, your support of this initiative; and our staff for their extraordinarily rigorous inquiry undertaken, beginning early this year, into this issue of falsified medical certificates.

I read over, last night and early this morning, the testimony of all the witnesses, and I am very encouraged by what I see. The response of FAA to the issue is a positive one and encouraging.

We do have the safest aviation system in the world. We do have the most complex aviation system in the world. But the fact that a number of certificated pilots have lied about grave medical conditions in order to retain their pilot's license is troublesome, worrisome, and in some cases, perhaps frightening. Surely, we can appreciate and be grateful for the statistics that the number of fatal accidents caused by medical incapacitation are low. But we shouldn't have to rely on the grace of God to get there.

A single impaired, intoxicated pilot could cause extensive and widespread damage to the public through loss of life or property damage. That is what the FAA wrote in an earlier rulemaking. FAA does require pilots to undertake periodic medical exams for fitness, but they are limited; they rely heavily on self reporting, and not all medical conditions are going to be obvious to a doctor who is seeing a patient for the first time, especially in the case of mental illness. And not all of these AMEs are as thorough as they should be.

The 2006 FAA survey, the Medical Service Airman Customer Satisfaction Survey—they have got these wonderful long words and usually they come down to an acronym—found that 15 percent of airmen reported their medical history had not been reviewed by their medical examiner. Seventy-nine percent had no medical history review done at all of that small 15 percent sample. But if you

extrapolate that survey result to the entire pilot population, it could be in 1986 that 89,000 pilots did not have an AME review their medical histories, and nearly 24,000 pilots did not have a physical exam done by an AME.

Now, the reason we have this AME process is so you have persons who are designated by the FAA who know what they are looking for, know what questions to ask, know what kind of exam to give, and they should not be subverted or averted.

Inspector General Scovel, in 2005, your office found egregious cases of airmen lying to the FAA about medical conditions in order to pass their medical exams. In the 40,000 pilot sample, the IG's Office found 3,200 airmen with current medical certificates simultaneously receiving Social Security disability pay. Forty of those cases ultimately were prosecuted, but hundreds more could have been prosecuted if they had had enough personnel in the U.S. Attorney's Office to do it.

Over a 10 year period, FAA's own researchers found 400 fatal accidents where pilots had potentially disqualifying medical conditions. I note with interest in Mr. Sabatini's testimony, his more detailed testimony, that FAA has gone through these and reduced it down to a very small number, small fraction; that if those exams had been done and if corrective actions had taken, and if a number of other things had happened, you would have had a fraction of a percent of irregular medical conditions. But that is not good enough and I think, Mr. Sabatini, you recognize that, and you have agreed to coordinate with the Social Security Administration.

In Social Security determination, if you are disabled, you are 100 percent disabled. Not so with the VA, which has gradations of disability. Some VA disability conditions may permit a person to continue to fly, but that is going to take very careful review. It is going to take very careful consideration of all those varying medical conditions.

I appreciate the seriousness with which Mr. Sabatini, Mr. Chairman, undertakes his responsibilities. He is a premier safety professional. But bringing together the National Driver Register, notifying airmen that they are subject to review through the National Driver Register I think is an important point. I am the author of the National Driver Register, over 26 years ago. Well, not quite the author; it was John Rhodes who preceded me by six years. But I did upgrade the National Driver Register and brought it to what it is today, and I think it is an exceptionally valuable tool in getting the full picture of airmen's conditions.

So I think, while this process has been uncomfortable, maybe even painful for the FAA, thanks to the Inspector General's Office, thanks to the NTSB, thanks to our investigative staff, the issues have been raised, they have surfaced, they have been examined, they have been evaluated, and FAA is on track to taking some vigorous steps toward resolution of the problem and creating an even safer airspace.

I will have some questions later. Thank you, Mr. Chairman.

Mr. COSTELLO. Thank you.

The Chair now recognizes the Ranking Member, Mr. Petri.

Mr. PETRI. Thank you very much. Thank you all for your testimony. This is an important subject, as the Chairman of the Full

Committee has pointed out, and it is good that we have oversight on it.

I wonder, maybe Mr. Sabatini might be the right one, if you could just sort of walk us through how the procedure works now and whether this episode or whatever has pointed out some ways of improving the procedure because of computerization and opportunities for cooperation between agencies and the like.

Mr. SABATINI. The current system today requires that in order to exercise the privileges of an Airman Certificate, one must have an appropriate medical certificate to accompany those privileges. Depending on the class of medical certificate, nonetheless, one must complete an application which has a host of questions, one of which specifically requires that you answer whether or not you have been convicted of a DUI, or driving while under the influence, and, in that instance, 100 percent of medical applications are matched or cross-checked with the National Driver Registry. If there is a positive hit, then there is a follow-up investigation that is conducted to assess that situation.

The system is dependent on pilots being honest, and if someone is intent on defrauding the system, as the Inspector General has discovered, then certainly that is possible. So the current system could stand to—as we have agreed—to have some improvements included, one of which is going to be adding a question to the questionnaire that specifically requires an answer to whether or not you are receiving disability benefits from any disability provider. And we will then, on a sampling basis, compare that with, starting with the Social Security Administration, a records match; and, of course, then follow-up investigation in that regard.

We are also proposing to not only do the cross-checking, but also to add the question, and we are strong advocates of educating the community in the many different ways that we can do that. So we can advise the community that this is now going to be on the medical certificate and make them aware that there is the potential for serious follow-up in terms of enforcement, whether it is from the criminal side or whether it is ours, from an administrative procedures side. We will vigorously follow up any indication that there is misrepresentation of one's medical condition.

Mr. PETRI. There have been stories in the press from time to time—I suppose they are accurate, though may be exaggerated—indicating that when people retire from the military or even from various civilian jobs, like being a bus driver or so on, they often discover they have some disability and that increases their retirement under some of the programs. I don't know how widespread that is in the Air Force or among pilots, but is that checked?

Mr. SABATINI. We do not now, today, have a method in place to check exactly what it is that you have suggested. But I would also tell you that is—and I don't have factual information, but I can tell you anecdotally that we know that there are military retirees who have a percentage of disability that, in and of itself, would not necessarily mean being disqualified, or having a condition that would prohibit the issuance of an FAA medical certificate. So we don't have any numbers on that, Mr. Petri, and that is the current state, but we hope to change that.

Mr. PETRI. One question. This works both ways, with Social Security, at least, and some of these other programs; people may be perfectly good pilots, but they may not actually have the disability that they are getting paid for. Was fraud discovered that way as this match was done, or was it only a check on the qualification of people to actually fly airplanes?

Mr. SABATINI. The investigation—and I might defer to the Inspector General who conducted the investigation—was primarily to assess people who were claiming disability and who also had a pilot medical certificate. And Social Security Administration disability is 100 percent disability, and once you have that, you would not qualify for an FAA medical certificate, so that would be a concern to us and we would want to ferret that information out.

Mr. PETRI. Maybe I should ask Mr. Scovel.

Mr. SCOVEL. Thank you, Mr. Petri. I do have some information that may help you understand the extent of that problem. We touched base last week with the Social Security Administration Office of Inspector General and we were informed that, to date, six cases of disability fraud from Operation Safe Pilot had been identified for their purposes. They report total monetary achievements—and that is their term—of \$499,706 achieved from Operation Safe Pilot. The breakdown includes \$425,160 in savings due to canceled benefits extrapolated over a period of five years; \$66,513 in fraud identified; and \$8,033 recovered by way of restitution.

It is clear that, while Social Security has identified six cases to date, they have informed us that they continue to work other cases, so a limited number of subsequent court cases may well come to our attention. Comparing that against the number of cases which we identified and which the U.S. attorney chose to prosecute, it is clear that the intent on the part of most of the pilots that we identified as investigative targets was to deceive the FAA, as opposed to the Social Security Administration.

Mr. PETRI. Thank you.

Mr. COSTELLO. The Chair recognizes the gentleman from New York, Mr. Hall.

Mr. HALL. Thank you, Mr. Chairman, Mr. Ranking Member, and our esteemed witnesses.

Inspector General, what do you estimate that it costs per prosecution to carry out Operation Safe Pilot, and would the FAA likely incur similar costs if they were to pursue administrative sanctions? If not, what would account for the difference?

Mr. SCOVEL. Thank you, Mr. Hall. We had an opportunity to evaluate the cost to my office of pursuing Operation Safe Pilot. They amounted to a total of \$401,192. The majority of that had to be charged to the direct labor hours of the investigation, but we also incurred administrative overhead costs, some travel costs, and other direct costs. That cost figure did not include FAA or U.S. Attorney Office costs, I should note.

The cost per case prosecuted—and I will note that there were 45 cases prosecuted—was \$8,915 per case. My testimony mentioned the figure of 48 cases. Those were the number of individuals that we referred to the U.S. attorney for consideration for prosecution. Three of those cases could not be pursued, as I mentioned in my testimony, two because the individuals died before the U.S. attor-

ney could bring charges and one because the individual was deemed to lack sufficient capacity to participate in his defense at trial.

Mr. HALL. Thank you. On another topic, during Operation Safe Pilot, did you find that the falsifications were more prevalent in the general aviation community or were cases where cargo or air transportation pilots were not being truthful? And do these categories pose a higher safety risk than GA pilots?

Mr. SCOVEL. Thanks. I will note that among the cases that we identified and referred to the U.S. attorney, there were 4 airline transport-rated pilots, 6 commercial pilots, 28 private pilots, and 7 student pilots. The figure of 28 private pilots, presumably all GA pilots, amounted to 62 percent of the number of cases we referred to the U.S. attorney. I don't think, and I won't say today on the record, that that indicates that general aviation pilots pose a greater threat. The reason, as I see it, that, in fact, 62 percent of our investigative targets happen to be private and presumably GA pilots was simply because of the investigative parameters that we and the U.S. Attorney's Office set. In other words, we were looking at the type of disability claimed, the nature and duration of the falsification that had been submitted to FAA as part of the medical certificate application, and also the U.S. attorney's prosecutive requirements; they basically were looking for open and shut cases. Applying all of those factors to the number of cases that we had under consideration, more private pilots—in fact, 62 percent—rose to the surface, and air transport pilots and commercial pilots represented smaller numbers.

Mr. HALL. Thank you, sir.

This one is both to Dr. Garber and to Mr. Sabatini. The Inspector General's testimony notes that the FAA and SSA are trying to work in compliance under the Privacy Act to create a list to cross-check applicants who may not have disclosed this potentially disqualifying type of condition. In your estimation, can the system be set up within the current structure of the Privacy Act or, at some point, does Congress need to consider amending the statute to allow the process to move forward?

Dr. GARBER. I think that that question probably would be better handled by Mr. Sabatini, as it goes to the sharing of information between those two agencies, so I will defer to him on that question.

Mr. SABATINI. What we are proposing is a notice in the Federal Register to inform the public about routine use of information that would be available through the Social Security Administration database and our database. As to the Privacy Act, I would have to defer to our attorneys to answer that question, since that is more of a legal issue, but certainly we would respect whatever the requirements are of the Privacy Act.

Mr. HALL. Are there technological or proprietary barriers to moving forward in terms of this coordination with SSA and FAA?

Mr. SABATINI. We are in discussions with the Social Security Administration, the Social Security Administration Office of the Inspector General, and, of course, our people, working out a memorandum of understanding on how best to implement this.

Mr. HALL. Thank you very much.

Thank you, Mr. Chairman. I yield back.

Mr. COSTELLO. The Chair thanks the gentleman and now recognizes the gentleman from New York, Mr. Kuhl. You pass? Very good.

The Chair now recognizes the gentleman from North Carolina, Mr. Hayes.

Mr. HAYES. Thank you, Mr. Chairman, and thank you very much for having a very worthwhile and thoughtful hearing on an important safety issue. I thank Mr. Oberstar, as well, for his interest and concern in this vital matter.

Thank you all for very extensive and informative testimony. As a pilot—I was just looking—the form that we fill out is quite comprehensive in nature and it can lead in a number of different directions. Safety is the issue which everyone in this room holds above—by considerable margins—anything else we are talking about.

So, with that as a backdrop, would you all care to speculate out loud about the dangers we face? We have talked about medical issues, we have talked about falsification, all of which are very serious. We have talked about jointly looking at double-dipping. All these are crucial. Having said that, again, do you have any concern that we might get beyond where we need to go and make this complicated form even more complicated, which, at the end of the day, puts a damper on the vital commerce provided by commercial—and that is an issue, because some of the things we do here concern commercial pilots—that the process may be slowed down for them. By the same token, general aviation and that group of pilots is important to business and commerce as well.

Could you just speculate for me about some of the precautionary measures that we, on both sides of the bench, should be aware of as we move forward in this very important process? Dr. Tilton, we have left you alone. May I start with you?

Dr. TILTON. Thank you, sir, for the question. I am certainly, obviously, very concerned. As you said, safety is paramount. I work for Mr. Sabatini in the Office of the Associate Administrator for Aviation Safety, so whenever I give a talk, the first thing I say is the safety of the airspace is number one; and then number two is to make sure, once we make that as the ground assumption, that every airman that we can possibly get back in the air, we do so. And we have a good record. Obviously, we are very concerned about the small minority of people who might take advantage of the system and give us incorrect information.

And I am concerned somewhat about making the process more complicated, but I think what we proposed are the correct level of response to the IG's investigation. I don't think that we are asking for any more ominous requirements on the part of the airman; we are just making the questions a little more explicit so there is absolutely no question in his or her mind that, when they answer the question, they are doing it correctly. And it give us one more opportunity to make sure the airspace is safe.

Certainly, I am not interested in making the system more egregious and difficult to participate in, but I think safety, again, is paramount in this situation.

Mr. HAYES. Thank you very much. At the risk of sounding like doing a promotion for AOPA, which is not my intention, I held up

the AOPA turbo medical, which is an online service that pilots who are for the first time or going to renew their certificate, can go online and look at some of the very complicated but relevant chemical and other issues there are. I am working with constituents right now. If you check off a block that says "have you ever been unconscious," then a whole host of things happens to you. In this particular case, there was an automobile accident and the law enforcement officer said the person was unconscious and he says he never was. Well, if he was never unconscious, his life is much easier. Again, neurological issues are important. I simply make the point, going forward, that I would encourage the continuation of this process, but filtering in as heavy a dose of common and practical sense as we can moving forward.

Again, this is kind of off the wall, it is not in the official questions, but is there an appropriate place to consider even a fourth class medical? It is kind of like somebody learning to drive. If you are out in the pasture and there is not a tree within 300 yards, and you are driving and learning, that is one thing. There is a lot of aviation that relates to that, as opposed to using sophisticated aircraft in congested area space. Good reason for first, second, and third class. Is there any fault, again, as a part of this effort, to improve safety and focus on the right areas that maybe even an additional to correspond with sport class license might be appropriate.

Mr. Sabatini or Dr. Tilton? Anyone. My time has expired.

Mr. SABATINI. Thank you, Mr. Hayes. We do not now have any thoughts about a fourth class medical certificate, but we do have different grades, the first, second, and third; and we also have, for light support aviators, other conditions under which they cannot safely operate. That was done through a very rigorous process of an NPRM and comments from the general public, and we are convinced that is a safe approach. So, in essence, there almost is something like a fourth class medical certificate.

Mr. HAYES. Thank you, Mr. Chairman. I have taken it over my time, but I appreciate your thoughtful responses as we work toward better aviation safety and a practical response. Thank you very much.

Mr. COSTELLO. The Chair thanks the gentleman and now recognizes the distinguished Chairman of the Full Committee, Chairman Oberstar.

Mr. OBERSTAR. Thank you, Mr. Chairman.

Dr. Garber, in your statement you allude to the number of aviation accidents where medical conditions contributed to, or were a factor, and say that that number is underestimated. What was your basis for that?

Dr. GARBER. Well, we don't have the resources, sir, the NTSB does not have the resources to do a complete aeromedical investigation of every single accident. We focus on those accidents where there is evidence, either from autopsy information, toxicology information, or the circumstances of the accident itself, suggesting in fact that there may be medical or medication issues in regard to the accident itself. So those are the ones that we look at.

Given that, there are probably some of those that we are not able to make a determination; there is simply insufficient information available, even with a comprehensive investigation, to come to a

conclusion as to whether or not the medical condition or the medication played a role in the accident. For that reason I say that the circumstances are certainly underestimated. To that extent, it is difficult to say, but I would say that we do a thorough job investigating those where we have significant information suggesting that the individual may have been impaired.

Mr. OBERSTAR. You had a staff review of 20,000 aviation accidents, which you reviewed, since 1995 and found 327 in which a medical condition, impairment or incapacitation, including over-the-counter medications, antihistamines and commonly known name of Benadryl. So it raises the question what makes a condition a disqualifying condition. Some of these are cardiac valve replacements; diabetes requires insulin; epilepsy. What other conditions are disqualifying? And what medications taken randomly, even over-the-counter medications, can cause incapacitation?

Dr. GARBER. Sir, I will speak a little bit to the medication issue in that the NTSB has recommended more comprehensive information be provided to pilots and other transportation operators with regard to the medication issue. There is no real comprehensive list of medications that are either disqualifying or permitted within the transportation industry or oversight regulatory area, so it is very difficult to determine which medications, from an operator perspective, would be allowed or would be disallowed if one was to indicate that they were using those; and we believe that that should be corrected. The NTSB has made recommendations in regard to that.

With regard to the question about the medical conditions which are disqualifying and why, I think I will defer that question to the FAA. They can give you more background as to why they have chosen the particular conditions that they have as being disqualifying in that regard.

Mr. OBERSTAR. I will pursue that in a moment. Recently, the Board made a recommendation that FAA should require airmen reporting conditions involving driving while impaired by alcohol or drugs to provide a complete copy of the relevant arrest report, including, maybe, court records. Why do you believe that is necessary?

Dr. GARBER. In the same way that the FAA requires records to be submitted on any disqualifying condition. If you were to mention to the FAA, as an example, that you had been in an emergency room for chest pain, they would request information as to the outcome of that evaluation and the specific information that was developed during that evaluation. In the same way, we think it is very important for circumstances like a DUI, which are significant indicators of a potential problem with substance abuse or dependence, should be evaluated more completely. An individual who may have had one or two drinks may not have an issue with abuse of the substance or dependence, but an individual who is driving on a very high level of alcohol may certainly be exhibiting evidence of tolerance, which, by the FAA's own definition, is an indication of substance dependence.

Mr. OBERSTAR. Well, I think it is an important recommendation and an important action to take because that arrest report gives a complete picture, not just a little slice, not just a little subtitle or headline; but it gives the medical examiner an opportunity for

a complete review of the circumstances. As Mr. Hayes referenced a moment ago, the question of “were you ever unconscious.” Well, under what circumstances? The arrest report would provide that kind of information.

In the course of NTSB review of all—you looked at 20,000 records, you at NTSB and your staff followed these issues very thoroughly, very carefully. Are you persuaded that the airman medical evaluation is rigorous enough? Should the whole process be reconsidered, re-evaluated?

I want to get Mr. Scovel’s reaction to that as well.

Dr. GARBER. The NTSB has made specific recommendations in a variety of areas; for instance, medications and substance dependence, as we have discussed here. Also, we have commented that we believe that there should be a reporting requirement to the system itself. The system itself, however, is fairly robust, like many other areas of aviation, and provides a significant review of those conditions under fairly strict guidelines, and in that regard probably is something of a model for other agencies, other organizations that share the same sort of regulatory oversight. There are areas for improvement, and the NTSB has certainly specified the areas where we believe improvement is both possible and should be made in the interest of safety. At the same time, we do recognize that this is a significant oversight function which is generally performed in a fairly substantial manner by the FAA.

Mr. OBERSTAR. Mr. Scovel, have you evaluated the airman medical review and do you think it is adequate as it stands, or should it be overhauled?

Mr. SCOVEL. Good morning, Mr. Chairman. I would begin by noting that my testimony this morning, of course, is based on Operation Safe Pilot, which was a criminal investigation project undertaken in one corner of the Country, really. We have not audited a full-blown audit of the Airman Medical Certification Program, so I am not able to say with authority that the program itself is systematically deficient.

I think we can say, however, based on both the results of Operation Safe Pilot and on the results of an FAA survey from 2006, which was referred to by the Committee earlier, that improvement in oversight certainly is to be desired. Operation Safe Pilot identified some limited systemic problems and we have suggested improvements to FAA and to the Committee to remedy those. The 2006 survey, which, to its credit, FAA itself undertook—it was not an IG project—identified problems, however, with the airman medical examination itself. Some of those examinations, as reported by airmen, had been conducted not by physicians, but by non-physicians. In a significant number of instances there was no detailed inquiry during the examination of the airman’s reported medical history. That too is required by FAA regulations. We would encourage the Committee and, of course, FAA to tighten up its oversight and the procedures involved in the actual examination that airmen undergo by Airman Medical Examiners, too.

Mr. OBERSTAR. Thank you, Mr. Scovel.

Dr. Tilton, are you satisfied that FAA’s AME is as good as it should be, needs to be?

Dr. TILTON. Sir, I am satisfied that the process—

Mr. OBERSTAR. And enough oversight of the process and enforcement?

Dr. TILTON. I am certainly satisfied that the standards we have and the process we have set up is correct. I am obviously not satisfied by results of the survey that the IG just told you about and that you have referred to because we always have concerns any time we find out someone is not complying or following the correct process. So, in the case of this particular survey, it was an anonymous survey, so how do we then proceed upon reviewing the results and making a determination? What we do is, we talk to our AMEs. And the purpose of the bulletin, where you noted that particular survey, is education to the AMEs on how they should be educating their airmen. The other thing that we do is, we go to air shows. For instance, in a week or so I will be at Oshkosh; we go to Sun 'n Fun and we talk to airmen directly. In every seminar we have with airmen, we talk to them about the importance of the system, and we also tell them if they find an AME like the ones that are reported in this anonymous survey, they should let us know. And when we know that information, we take positive action against that AME to make sure that he or she is appropriately disciplined, including de-designation.

So although I think we need to do more, we always can do more, I think we have a good system. We need to keep looking at it and making sure that every time we find information like this, we take positive action to correct it.

Mr. OBERSTAR. Well, taking the positive action is critically important, and strong enforcement action.

Mr. Sabatini, an FAA researcher last winter found, during a 10 year period, 10 percent of pilots involved in fatal accidents tested positive for medications used to treat potentially disqualifying medical conditions, but only 20 percent of them reported their medical condition on their airman application. Is that acceptable?

Mr. SABATINI. Absolutely not, sir. As I said in my opening comments and my closing comment, safety is paramount for us, and every system can stand improvement, and I can assure you, Mr. Chairman, that we will vigorously pursue anyone who falsifies information provided as required to be provided.

I would also like to point out that while this report, this survey that is being discussed here was exactly that, it was anonymous to solicit information, again, it is an indication of how the FAA is being vigilant to assess what is going on in a system that is highly dependent on voluntary compliance.

I would also add that the recommendation that was made by the NTSB has been taken very seriously by us, and, in discussions as recent as this past week, I can assure you that we will be taking the kind of action that is going to require an airman to provide us with the full record of that person's arrest or conviction, or whatever the case may be, as well as exploring whether we can, in fact, get that record from the law enforcement organization. So it is a new area for us, but we take very seriously what has been recommended. It makes good sense. There is a possibility of tolerance. That is unacceptable in our community, and we are working vigorously to address these areas of, as has been said, in the area of oversight.

I would also tell you, as Dr. Tilton has said, the standards that we have are global standards. We are sought after and asked to share with the global community how we go about the business of certifying from, a medical perspective, our airmen. So I believe the standard is more than adequate and I would tell you that the FAA is vigilant and will continue to be vigorous in its pursuit of anyone who misrepresents information.

Mr. OBERSTAR. We are counting on you to be vigilant. We are counting on FAA to be the gold standard for the whole world in all of aviation safety, and that means pursuing these matters vigorously. In that analysis of the research, 40 percent of those pilots were rated for air transport or cargo operations. It didn't say whether they actually were operating as Part 121 pilots, but it is troubling that apparently these more stringent medical exams were not applied in those cases. You are going to correct that?

Mr. SABATINI. Oh, absolutely, sir. Yes, sir.

Mr. OBERSTAR. All right, thank you.

Thank you, Mr. Chairman.

Mr. COSTELLO. Thank you.

The Chair now recognizes Mr. Reichert.

Mr. REICHERT. Thank you, Mr. Chairman. I would like to follow up on a couple of comments and a couple of lines of questioning by Mr. Oberstar and Mr. Petri that has to do with process.

I am not a pilot, but I fly a lot as a passenger, and have over the last number of years. But what I have done in my past career is investigate; 33 years with the sheriff's office in Seattle. My last eight years was as the sheriff. We have an air support unit there, so I have been responsible for, of course, making sure that our pilots are trained well and meet the medical requirements. And as you know, safety, of course, is our number one priority in the sheriff's office, too. And here, today, we are talking about safety and keeping our airlines safe and the pilots safe and the passengers safe.

Again, the process is—it seems like there are a lot of moving pieces here, for me. The medical evaluation and the medical application is completed; there is an employment application. Does that marry up? Do those two documents marry up when the pilots apply—in the case of a commercial pilot—to the airlines for a job? How does that work? Or do they have their own separate medical document that they need to complete?

Mr. SABATINI. First of all, let me say that we have a lot in common. I am a retired New York City police officer, spent 20 years in the NYPD, 11 of those years flying in the air unit. So I am very familiar with that kind of support.

Mr. REICHERT. Thank you for your service.

Mr. SABATINI. I would say that the medical certificate is required to be provided as evidence to a potential employer as to the qualifications that are required for that particular position. You will then be subjected to, say, an air carrier's own medical examination as well. So, in that sense they come together. Whether the air carrier in fact researches the medical certificate, I can't answer that with certainty at this point in time.

Mr. REICHERT. You know, in the NYPD and in the King County Sheriff's Office, as you go through this process of hiring someone,

a medical application is completed, there is a release that is signed for medical records. Does that occur in the pilot field?

Mr. SABATINI. Before someone can be hired in the air carrier world, I know the acronym, I can't think of the actual description, but it's the pilot record, PRIA, that has to be complied with in terms of—the air carrier has access to the previous history of the pilot, and I believe that will include the medical certificate as well.

Mr. REICHERT. So as these applications are completed, is there—we have background investigators that go out to the sites and visit with neighbors and friends of people applying for a job. Is there a polygraph given to prospective employees of airline companies?

Mr. SABATINI. I don't know of any air carrier, so I can't speak with authority on it, but I doubt that there would be a polygraph. There are many examinations that are required, written exams or questions that need to be answered. But I will tell you this, that the system is a robust system. Before someone actually ends up at the controls of an aircraft—and let's use the air carrier world as an example—one must go through required training, basic indoctrination to that air carrier's system. And that is not an option, it is required by Federal regulation. Once the training is complete, then that person must demonstrate through a flight check with their own instructors that the person is competent and proficient in that particular pilot station that person may be sitting in; then followed by an FAA proficiency check to ensure that that person can in fact execute the responsibilities of that position.

Mr. REICHERT. Thank you. My time is really going by here fast. In the law enforcement world, you fill out this application, you know, "have you used drugs in the past;" and, of course, there are time limits on some of the more major drugs. Marijuana is also listed on there; how long ago did you use it, those sorts of things. And when those questions are asked on the medical application, the polygraph test is given and they say on the application "we have never taken this drug, we have never taken this drug," and it has been 10 years since but it has been 5 years in reality. A polygraph test catches that sort of thing.

The other thing is, we have a fit-for-duty, as you know, in law enforcement. When you recognize something with a pilot, is there a fit-for-duty examination?

And the last comment I want to make here, before you respond, is the connection between SSA and the FAA and medical records—and you say if they are on Social Security, there is 100 percent disability. There is no need, then, to really know what the personal medical history is if the Social Security system has already reviewed that, given the 100 percent disability. All you need to know is if he or she is on Social Security, and they are gone.

I am over time, but could they answer, Mr. Chair? Thank you.

Mr. SABATINI. That is true. We would, at that point in time, if it was an SSA disability, that person would automatically be disqualified. But there is a due process that we must follow and revoke that medical certificate.

Mr. COSTELLO. The Chair thanks the gentleman.

Mr. Sabatini and Dr. Tilton, you have heard from the Chairman of the Full Committee, Chairman Oberstar, and I think other Members of this Subcommittee were pleased that the FAA is moving in

the right direction to correct some of these problems, one, by looking at the database and working with the Social Security Administration; two, by revising the form to specifically ask the question if the applicant is receiving any disability. So we are pleased that you are moving in that direction.

You heard Mr. Scovel testify that there are improvements that need to come about in oversight. Also, the fact that there were some examinations apparently given by non-medical doctors. I want to give both of you the opportunity to comment on both of those issues, on improving oversight and the fact that apparently some examinations have been given by non-medical doctors. I wish you would comment on both, please.

Mr. SABATINI. Sir, let me give you my first response in terms of non-medical. Again, it is the FAA aggressively pursuing information that can help us be good at the work that we are responsible for, and that is the oversight of the system. I would suspect that—first, let me say that no one has ever been issued a medical certificate that was not signed off by a doctor. So perhaps in the office—and this is speculation on my part, and that is the issue that we have in terms of surveys that are anonymous—we can't pursue that person and find out exactly what they are referring to. But it is possible that there are physician assistants who performs a preliminary medical examination and then present the information to the doctor in the office, and that doctor is then required to, of course, be the person who signs off on the medical authorization and the issuance of the certificate.

But I will turn to Dr. Tilton and ask him to expand on that.

Dr. TILTON. I agree with what Mr. Sabatini said. It certainly is possible that occurred. It is not in line with our process. We do use ancillary personnel to do things such as EKGs or draw blood or check the blood pressure, but the AME, he or she, is duly responsible to do that examination; they are required to lay hands on the patient, to do the various tests that the physician should be doing to ensure to him or herself that that is done correctly.

Whenever we find out that there is a case where that hasn't been done, we take aggressive action against that AME. It is difficult sometimes to get that information, and we have heard anecdotes about some people traveling a long way to get their physical because they know if they pay such an amount of money, they will get it without a whole lot of difficulty involving the AME himself. When we find out about that case, we take action against those; and we rarely find those. In fact, we have a process now that we look at all our AMEs; we look at how many examinations they do, we look at where they are located, we look at how far people travel to get to that AME to compare distances. For instance, if someone has traveled 3,000 miles to get their physical—why? We have a good example of that in Prescott, Arizona. Although Prescott, Arizona has the school Embry-Riddle, so there is good reason why people coming from some other State might have their physicals there. We haven't found any meat in that data, although we have reviewed it very carefully.

I am very concerned about this information where we hear that an AME has not done the physical correctly or they haven't seen

the doctor, and when we find that out, we will take aggressive action to make sure that doesn't happen again.

Mr. COSTELLO. Dr. Garber mentions in his statement the fact that he talks about anonymous reporting, and I am just curious how many anonymous reports on a pilot's medical condition does the FAA receive? Is it a large number or is it rare that someone anonymously reports a medical condition to the FAA of a pilot?

Dr. TILTON. Sir, I wouldn't say it is—it is not every day, but it is not rare, either. We get several anonymous reports yearly, and what we do with those reports is we immediately go out to that airman and we acknowledge that we have information that may affect that airman's privileges, and we ask them for more information. Of course, with an anonymous report, sometimes we find out it was somebody who had some kind of reason, an ex-wife or something, and that does occur occasionally. But we do take action; we ask for more information. Sometimes we get family members saying, you know, my husband is 86 years old and I am really concerned and I don't want to do anything about it myself, but I would really like you to do something. We will pursue that; we will ask for more medical information to see if there is substance. If there is substance, we take action.

Mr. COSTELLO. Last question. I think we all recognize that some pilots have intentionally failed to disclose information on their applications and others inadvertently leave off, omit, or fail to report either medication or other debilitating illnesses. Both the IG and AOPA have suggested that there should be an amnesty period before we begin to do the match-up, the matching program, and I just want your comments, Mr. Sabatini and Dr. Tilton. Do you believe that we, in fact, should proceed with an amnesty program? Please.

Mr. SABATINI. I believe a grace period would be an appropriate action to take, but I would caution so that we all understand. In those circumstances where someone were to reveal a medical condition that would be disqualifying, we would still take the appropriate revocation action of that medical certificate, even though they came forward voluntarily and revealed that condition. In other circumstances we would not pursue any punitive action.

Mr. COSTELLO. The Chair thanks you, Mr. Sabatini, Dr. Tilton, Dr. Garber, and Mr. Scovel, for your testimony today, and we look forward to following up on this important issue with the FAA as they move forward to implement this program. We thank you, and the first panel is dismissed.

We would ask the second panel, consisting of one witness, to come forward, please.

Let me recognize and introduce our sole witness on the second panel and let Members know, and the first panel know, of course, as always, that there are questions that we will submit both for the first panel and Mr. Boyer, as well, in writing for the record. So we want both Members and witnesses to know that.

We recognize now Mr. Phil Boyer, the President of the Aircraft Owners and Pilots Association, for his testimony. And let me say, before you present your testimony, Mr. Boyer, we greatly appreciate both you and your organization taking this issue very seriously and coming up with a four-point plan to address the issue,

and we look forward to hearing your testimony and hearing you explain what that plan is about.

**TESTIMONY OF PHIL BOYER, PRESIDENT, AIRCRAFT OWNERS
AND PILOTS ASSOCIATION, FREDERICK, MD**

Mr. BOYER. Well, thank you, Mr. Chairman. Just before starting, not exactly the appropriate place, but I would like to thank you, your leadership, the Committee, Ranking Member Petri for a really sane approach to financing the entire FAA, not just the section we are talking about here. You have our undivided support of all of our membership for H.R. 2881.

You know about us, 412,000 members. That is two-thirds of all of those certificates that were reported earlier. And, in the main, many of these are the private pilots that we were talking about. The organization has always taken medical services very, very seriously. As a matter of fact, there are about 30,000 member contacts a year, 13,000 of those by phone that we answer. So it is a good example of industry and the industry self-policing itself. We even cover non-members. We talk about medical action in magazines and in our electronic publications, including the website.

Let me tell you—and pardon me, Mr. Graves, for talking about something you know about—a medical certificate is a pilot's most prized possession. It is sacred. I mean, getting a license is one thing, but let's not forget, you must be medically certified to be in one of these categories that we are talking about. Therefore, when ramp checked or anything else, a pilot has to have not only the original license of issue, but also that medical certificate, and since 9/11, through the actions of our group, a photo ID.

Once again, pardon me, Sam, but just to clarify, there are three levels of medical certification. The third class, that is somebody who flies not for hire, generally taking a family, a business associate, somebody who knows them up; not, as was mentioned, somebody who is flying or taking up in law enforcement. That is good for three years except, for most of us over 40, for two years we go to the doctor. And, actually, there is a proposal and a ruling right now on the docket that would—a notice of proposed rulemaking that would extend that period to five years. It is an example of our talking about an issue that is constantly changing. The technology, the medicines really do need to be looked at, and not stay with rules from 1940 or earlier, when we are looking at what we certify and what we don't certify; and, as we all know, that brings us a lot of longevity.

The second class medical, which is the first place in which you would fly for hire or carry passengers, is used for the commercial pilot certificate. It is good for one year. And then the airline pilots that we were talking about have to go for a medical—and the corporate aircraft—every six months. And this rulemaking I talked about is being proposed to extend that to one year.

One thing that wasn't brought up that I think is very, very interesting and should be considered as we talk about that is the FARs continue to emphasize that the pilot must determine that he or she is healthy to fly before every flight. And it is a violation of the rules—whether you are taking an antihistamine, a prescription drug, or whatever—if you are not self-certifying before flights. And

those of us who have flown many times know bad cold, maybe an injury to the foot or something that might affect a rudder pedal is a reason we might have another pilot onboard flying our plane.

Just to look at the misconception out there is—you heard a lot of statistics. In the end, we are dealing with reasonable people who don't want to go out and kill themselves and their family; a very conservative group of people who will ground themselves before flights when they are taking a medication or have some other kind of medical situation; and medical incapacitation is rare. One-quarter of one percent of all accidents are due to medical incapacitation.

Now, you heard larger numbers than that, but that would be like me looking at somebody who had 50 stab wounds, was obviously killed, and then we examined that individual and found that they may have had a plaque buildup in their arteries. The real reason were those 50 stab wounds. The plane ran out of fuel or this or that. But, once again, you heard that word "possibly." The actual data shows one-quarter of one percent. And if we look at medical fraud, five-one hundredths of one percent. Now, once again, we don't condone any kind of falsification of fraudulent records.

And I will tell you, in preparing for this, in talking to the Committee, and in really seeing the IG's report, as a 40-year pilot, I was never aware that this complicated form that Congressman Hayes referred to—that there were these kinds of penalties if we didn't get something right; and I will tell you, it is not difficult to forget that doctor's exam that you went to. I just was thinking about, now, where would that apply to me when I go in next April. And, you know, I went to the doctor about four months ago for a sore in my heel. Turned out to be a burr caused by a shoe. I might forget that when I am going to an AME. It had nothing to do with my flying. And that would be counted as a falsification of the record. So we have got to understand that there are inadvertent errors.

There is a question 17 on here: Do you take any non-prescription medicines? Somebody starts filling it in and it causes you to be kicked back if you, once in a while, take a Tylenol. Believe me, in this job, and I am sure in your jobs, you have to take one of those every once in a while.

One of the things I think we want to protect is, that the FAA budget, the Civil Aviation Medical Institute is not well funded; it is a flat budget. The people that you are looking for—Sabatini and Tilton—to do all this fact checking are not given a great budget, and right now many of your members probably write you and say, "could you help me get my medical; I've put in all the paperwork and it doesn't come through." That is because this area of FAA has never been given the proper money. So if we are going to do other things, let's make sure the FAA has the budget to do them.

And I think the four-point plan that we have outlined—and I am not going to take a lot of time on it because, actually, you are aware of it in my testimony and it has been spoken to already, but we ought to have a warning on the form, a public disclosure that the data will be shared with public agencies. Let's face it now, security agencies are looking at this, not just the driver record. So let's add to that all agencies. And, you know what? In September of 2005, when the IG report first came out, we wrote a letter to the

FAA saying let's do this; not waiting for this Committee to have a hearing or anything like that.

Proactively, let's look at identifying falsifications. So let's say I had filled out that application last April and I hadn't talked about this little burr on the heel of my foot when I visited a doctor. Once again, not disqualifying, but I didn't put that I had that physician visit. Let's give this amnesty period we talked about for people to clear up things like that; not that I had heart bypass surgery and I didn't put it in. I mean, they will have to go through the rigors of getting back in.

And then I think one of the most important things is a data sharing program. Let's not put the onus on the FAA. They don't have the budget to do this, and it is going to slow down, it is going to increase your e-mail and letter flow, and mine, to help pilots as our constituents.

But the most important thing is we will help. With the size of our publications, the size of our organization, the many ways to reach pilots, we will get back in and talk about the changes that will occur to the medical form. For more than four years we have had, like Turbo Tax, a medical form online. It was referred to here by Congressman Hayes. It allows you to go through, and if you make a mistake or fill in a box wrong—this is before you go to the doctor—it kicks it back and says that medication is not valid under FAA rules, you may want to try this kind of beta blocker or something else.

For four years we tried to get the FAA to accept this form. They spent a lot of money and now have just recently come out with their own electronic form, so now they are saying, okay, we will accept yours. We had already spent the money and could have done it for the FAA, but it is out there and we will promote that.

The penalties—things I didn't know about—we would love to let members know that, careful now, this is an important form, and if you make a mistake on it, you could be subject to these onerous penalties that are out there.

And the amnesty period. Anything that has to do this. Pilots are very law-abiding people and, believe me, they don't want to defraud the Government. They don't want to fly unsafely.

And I thank you very much for allowing me this time to explain what I think would be a great program for the FAA and for AOPA to undertake.

Mr. COSTELLO. The Chair thanks you, Mr. Boyer, and recognizes the Ranking Member, Mr. Petri.

Mr. PETRI. Thank you. Thank you for your testimony. Obviously, much thought and work was put into it; it was a very professional job. I think it does remind us all that we are, in our Country, self-governing, and that is how the system really works and works best, and if it is driven by the people who are involved in these systems, they have the best sense of what is working and what is not working, and also incentive to make it as effective, but also as simple and user-friendly as possible. I hope you may be in Oshkosh. I don't know if you are going to be there next week or not. Not this year?

Mr. BOYER. Oh, I am there for two different sessions.

Mr. PETRI. Oh, you are.

Mr. BOYER. Four days total.

Mr. PETRI. Then you know the manifestation of pride in aviation, and in our Country, really, that is there, and it is a unique kind of a thing in all kinds of subtle ways. So anything we can do to help you and your association as you promote safety and, at the same time, attempt to make this an open and accessible process for Americans so that they have the freedom to engage in this aspect of science and of life, we are eager to work with you on that. Thank you very much for your testimony.

Mr. COSTELLO. Thank you, Mr. Petri.

Mr. Boyer, I had just a few questions, and you answered them in your presentation, so I have no other questions. As you indicated, we had a prior discussion several weeks ago, and you put together what I think is an action plan that is workable and makes sense and is very reasonable. We look forward to working with the FAA and other agencies that will be involved in the process to follow up as the process goes forward.

I do believe there should be a grace period. There are many pilots out there that, as I mentioned earlier, some may have intentionally failed to disclose, but many, many others it is just an omission on their part that they forget to put on the form. So I believe there should be a grace period, and I think a one-year grace period, as AOPA is proposing, is reasonable.

So we thank you for your testimony. We thank you for your always being proactive, and that concludes this hearing.

[Whereupon, at 11:35 a.m., the Subcommittee was adjourned.]

STATEMENT OF
THE HONORABLE JERRY F. COSTELLO
SUBCOMMITTEE ON AVIATION
HEARING ON
FAA'S OVERSIGHT OF FALSIFIED AIRMAN MEDICAL CERTIFICATE APPLICATIONS
JULY 17, 2007

- I want to welcome everyone to this hearing on the *FAA's Oversight of Falsified Airman Medical Certificate Applications*.

- In July 2005, the Department of Transportation's Inspector General found "egregious cases" of pilots failing to disclose debilitating medical conditions on their applications for Airman Medical Certificates. The U.S. Attorney's Office prosecuted more than 40 cases, but hundreds more could have been pursued if adequate resources had been available.

- The DOT IG made three recommendations in that report and FAA is actively pursuing those recommendations. In April 2007, the FAA began working to implement a strategy

and system to coordinate with the Social Security Administration to verify information on Airman Medical Certificate applications. Further, the FAA is revising its application form to explicitly ask the applicant if they are receiving medical disability benefits. Both are important changes and I am interested in hearing more from Nick Sabatini and Calvin Scovell on this development.

- The FAA has some of the strictest medical requirements in the world. By taking the necessary steps to improve the process by establishing a way to verify medical information reported to the FAA, we continue to ensure the safety of the pilot and that of the flying public.
- I am also pleased that AOPA, the largest civil aviation organization in the world, has developed a four point plan of

action to educate pilots and to address the problem. I am interested in hearing more about this from Phil Boyer.

➤ I have continuously said that although the United States has the safest air transportation system in the world, we cannot rely on or be satisfied with our past success. We must all work together to ensure the highest level of safety for the traveling public.

➤ **Before I recognize Mr. Petri for his opening statement, I ask unanimous consent to allow 2 weeks for all Members to revise and extend their remarks and to permit the submission of additional statements and materials by Members and witnesses. Without objection, so ordered.**

Statement of the Honorable Doris O. Matsui
House Transportation and Infrastructure Subcommittee on Aviation Hearing
"FAA's Oversight of Falsified Medical Airman Certificate Applications"
Tuesday, July 17, 2007

Thank you, Mr. Chairman. I ask unanimous consent to revise and extend my remarks.

[Without objection, so ordered.]

Chairman Costello, thank you for calling this hearing today. This hearing builds off your already strong record protecting the safety of the flying public. As someone who flies frequently—as most of us do—I appreciate your focus on making America's airways safe and secure.

Mr. Chairman, we are not here to debate whether or not some pilot applicants commit fraud. This is something we already know. Some people want to fly so badly that they will lie about their medical history. They will commit this crime even though they know it endangers the lives of others.

Doris O. Matsui

The evidence of this is right here in front of us. The Inspector General of the Transportation Department has issued a thorough report documenting over 3,000 cases of this kind of fraud.

People who live in my hometown of Sacramento committed some of the most serious of these crimes. They endangered the lives of those who flew with them ... and of those who live, work, and play underneath their flight paths.

These crimes must stop. If the airways near and above my district are being flown by people with questionable medical conditions, I want to know about it. And I want to take action.

That is why I am encouraged that the Committee has brought this issue to light with today's hearing. We simply cannot allow people to gamble with people's lives in the air.

But this is just what pilots do when they falsify their medical airman certificates. For pilots, lying about medical history is like making a deadly wager, Mr. Chairman. In essence, these dishonest applicants gamble that their health conditions will not affect their ability to fly.


Tragically, this is not always the case. When these renegade airmen lose their bets, the consequences can be disastrous. They can be fatal.

I know I speak for all my colleagues when I say that we want to address this growing problem.

Thankfully, we do not have to start from scratch. The Inspector General has recommended a clear way forward for us to solve this problem. These steps are a strategy we can implement ... right now ... to help reduce the deaths and injuries caused by airman certificate fraud.

I would like to thank the Inspector General for providing us with such clear recommendations. I look forward to hearing how the FAA plans to implement these common-sense reforms. Doing so will make our skies safer. It will save lives in my district and across our country.

Thank you, Mr. Chairman, and I yield back the balance of my time.

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Statement of Rep. Harry Mitchell
House Transportation and Infrastructure Committee
Subcommittee on Aviation
7/17/2007

--Thank you Mr. Chairman.

**--The safety of airline passengers depends
upon pilots who are physically and mentally
fit to fly.**

**--FAA medical exams, however, rely heavily
on self reporting and as a result, many pilots
do not reveal their full medical history.**

--In 2005, the Department of Transportation Inspector General uncovered “egregious cases” of airmen lying about debilitating medical conditions on their applications for Airman Medical Certificates.

--Out of a sample of 40,000, the Inspector General found 3200 holding certificates while simultaneously receiving Social Security benefits, including those for medically disabling conditions.

--This is clearly unacceptable.

--We need to ensure that pilots are not only technically qualified to fly, but also are physically and mentally fit to do so.

--I look forward to hearing from today's witnesses to learn what we can do better protect the flying public from pilots who are unfit to fly.

--I yield back the balance of my time.

STATEMENT OF
THE HONORABLE JAMES L. OBERSTAR ON FALSIFICATIONS OF AIRMAN MEDICAL
CERTIFICATES
JULY 17, 2007

The United States has the most complex aviation system in the world and it is also the safest. FAA's oversight is largely responsible for the extraordinary level of safety seen in this country for the past 5 years.

That said, I have serious concerns that the FAA has failed to adequately enforce a critical safety requirement in its licensing of pilots. A significant number of certificated pilots have lied about grave medical conditions in order to get a pilots license. FAA knows this is happening but has done nothing to catch and put a halt to this fraud.

The FAA has some of the strictest medical fitness requirements in the world because there is irrefutable scientific evidence that medically unfit pilots pose a real danger to themselves and the public. The numbers of fatal accidents caused by medical incapacitation are low, but by FAA's own admission in a prior rulemaking, "A single impaired or intoxicated pilot could cause extensive and wide-spread damage to the public through loss of life or property damage."

The FAA requires pilots to pass periodic examinations to determine medical

fitness. But these exams are limited and rely heavily on self-reporting. Not all medical conditions are going to be obvious to a doctor who is seeing a patient for the first time. This is especially true for mental illness.

Furthermore, not all AME's are as thorough as they should be. Results of the 2006 FAA Aerospace Medical Services Airman Customer Satisfaction Survey found that 15 percent of airmen reported that their medical history had not been reviewed by their AME. Of those, 79 percent had *no* medical history review done at all.

Another 4 percent reported that the AME had not done the physical exam. Thirteen percent of those pilots report no physical exam was done at all!

Extrapolating the survey results to the entire pilot population would suggest that in 2006, *89,000 pilots* did not have an AME review their medical histories and nearly *24,000 pilots* did not have their physical exam done by an AME. Clearly, FAA's medical oversight process needs improvement and this committee will continue to investigate these issues.

In July 2005, the Department of Transportation Inspector General found what he called "egregious" cases of airmen lying to the FAA about medical conditions in order to pass their medical exams. Of the 40,000 pilots in the sample, the Inspector

General found more than 3,200 airmen with current medical certificates that were simultaneously receiving Social Security disability pay. While the U.S. Attorney's Office ultimately prosecuted about 40 cases, hundreds more could have been pursued if the US Attorney's resources had not been constrained.

The Inspector General recommended that the FAA develop an arrangement with Social Security and other disability providers to target individuals who are claiming to be physically and mentally healthy for the FAA's purposes, while simultaneously claiming benefits for physical or mental disabilities.

During a ten year period, FAA's own researchers found nearly 400 fatal accidents where pilots had potentially disqualifying medical conditions. This represented about 10 percent of the pilots involved in fatal accidents during that period. The research team found evidence of drugs used to treat mental illness, cardiac disease, and neurological disorders. Fewer than 10 percent of these conditions had been reported in the pilots' most recent medical certificate applications.

A recent NTSB study also found 327 aviation accidents in which impairment, incapacitation, or a medical condition were identified as causes or factors. And the NTSB points out that this number is certainly an underestimate of the extent to which these conditions are factors. In many cases the evidence is insufficient to completely

evaluate the possibility of impairment.

Despite these findings, the FAA has not yet developed a process to check for false information on medical certificate applications. Mr. Sabatini, FAA's top safety official is here with us today, and has publicly called false statements on medical certificate applications, "extremely serious." I understand that since the March 19 committee staff report on FAA's oversight of the medical certification process, FAA has begun to reach out to the Inspector General and the Social Security Administration to explore some possible methodologies. I look forward to hearing more about these steps from Mr. Sabatini and Dr. Tilton today.

These efforts will be a critical first step for FAA to improve oversight of its medical certification process. Even if FAA samples only 1 percent of the certifications each year, the fear alone that your number will be called -- will be a powerful incentive for pilots to be more forthcoming about their medical conditions.

I look forward to hearing from all of our witnesses today.



AIRCRAFT OWNERS AND PILOTS ASSOCIATION

421 Aviation Way • Frederick, MD 21701-4798
Telephone (301) 695-2000 • Fax (301) 695-2375
www.aopa.org

Statement of Phil Boyer, President

Aircraft Owners and Pilots Association

before the

**Transportation & Infrastructure Subcommittee on Aviation
U.S. House of Representatives**

concerning

Falsified Pilot Medical Certificates

July 17, 2007

Good morning, Chairman Costello and Congressman Petri. Thank you for the opportunity to testify today on falsified pilot medical certificates. I am Phil Boyer, President of the Aircraft Owners and Pilots Association (AOPA).

AOPA is a not-for-profit individual membership organization of more than 412,000 pilots. AOPA's mission is to effectively serve the interests and needs of its members as aircraft owners and pilots, and establish, maintain, and articulate positions of leadership to promote the economy, safety, utility, and popularity of flight in general aviation aircraft. Representing two thirds of all pilots in the United States, AOPA is the largest civil aviation organization in the world.

AOPA's Efforts to Help Pilots With FAA Medical Requirements

In speaking on the important issue of falsified pilot medical certificates, I am relying on our experience and expertise garnered from assisting pilots in complying with Federal Aviation Administration (FAA) medical standards and requirements. The association has a team of four Medical Certification specialists that work directly with pilots, answering more than 30,000 inquiries a year on the FAA's medical certification process. Our Medical specialists coordinate closely with the FAA Aeromedical Division in Oklahoma City and with the Office of Aerospace Medicine in Washington to ensure that the information provided to members is accurate and comprehensive.

AOPA also advocates for changes to FAA medical standards and policies as advancements are made in medicine and technology. This assists the agency in keeping the medical requirements current and reflects changes made by the medical profession. In addition to our team of experts, pilots may also access AOPA's Web site, (www.aopa.org) for detailed information on FAA medical requirements (refer to attachment A).

An important part of this Web-based information is AOPA's TurboMedical interactive online tool designed to help pilots complete the FAA Airman Medical Application (Form 8500-8 Application for a Medical Certificate). TurboMedical provides information on medical conditions and medications based on answers supplied by the applicants and informs pilots of the additional information that may be needed at the time of their next medical application (refer to attachment B).

FAA Medical Standards Ensure Highest Levels of Safety

The FAA uses a three-tiered system of medical certificates. First class medicals are the highest level of medical review that must be renewed every six months, required only for airline pilots (captains). Second class medicals are required for pilots engaged in other commercial operations, such as air charter operations and require a physical exam and renewal every year. Private pilots, who are not permitted to accept compensation for flying are required to hold a third-class medical certificate from the FAA. The third-class medical certificate is valid for 36 calendar months if you are under 40 years of age and 24 calendar months if you are 40 or older.

To obtain a medical certificate, you must complete an official FAA application form (FAA Form 8500-8 Application for a Medical Certificate) and pass a physical examination administered by an FAA-authorized aviation medical examiner.

In addition to holding a medical certificate, FAA regulations require pilots to self-certify prior to every flight that they are healthy and able to safely operate the aircraft. Federal Aviation Regulation 61.53 requires a pilot who "knows or has reason to know of any medical condition that would make the person unable to meet the requirements for the medical certificate necessary for the pilot operation" to self-ground.

The combination of FAA medical certificates and regulatory standards for being "fit to fly" has resulted in medical incapacitation being a rare cause of accidents. As a group, pilots are reasonable people who exercise conservative judgment in interpreting the regulations and exercising piloting privileges prior to each flight, including grounding himself or herself if they feel that they cannot safely act as pilot in command. According to statistics compiled by the AOPA Air Safety Foundation, accidents resulting from medical incapacitation are so rare that they only account for a quarter of one percent of all accidents between 1995 and 2004.

AOPA Does Not Condone False Statements On A Pilot's Medical Application

Let me be clear, AOPA does not condone false statements or omission of known disqualifying medical conditions on the FAA Form 8500-8 Application for a Medical Certificate. The FAA and Justice Department can and do impose severe penalties on those who fraudulently misrepresent their medical histories when completing the FAA Form 8500-8. The form clearly states, "Whoever knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious, or fraudulent statements or representations, or entry, may be fined up to \$250,000 or imprisoned not more than 5 years, or both."

For many pilots, a periodic visit to the aviation medical examiner to renew their medical certificate is a routine ritual that goes hand in hand with the privilege of flying. Complacency sometimes fosters carelessness, and can result in an inadvertent or unintentional omission on the Form 8500-8 of what the FAA may consider pertinent medical information. Yet, these mistakes do not warrant FAA enforcement actions or criminal charges.

Recommendations to Address Transportation & Infrastructure Committee Report; *FAA Oversight of Falsifications on Airman Medical Certificate Applications*

In July 2005, a Department of Transportation Inspector General Memorandum noted the falsification of FAA airman medical certificate applications by some Social Security disability recipients. In March 2007, the House Transportation and Infrastructure Committee issued a report entitled, *FAA Oversight of Falsifications on Airman Medical Certificate Applications*.

AOPA has developed a four-step plan to address the concerns of the Committee and Department of Transportation Inspector General regarding falsifications or

omissions on medical certificate applications. This plan includes modifying the medical application, updating airmen records, establishing a data-sharing program and educating pilots.

First, AOPA recommends the FAA modify the Form 8500-8 Application for a Medical Certificate by adding a statement warning pilots that information provided can be shared with other government agencies including the Social Security Administration. This statement would be similar to the existing warning regarding the checking of the National Driver Registry. In fact, following the DOT Inspector General's investigation and Memorandum, AOPA made this request in writing to the FAA in September 2005 (refer to attachment C).

Second, AOPA recommends the FAA establish an amnesty period of at least one year during which airmen may avoid enforcement action if they volunteer previously unreported information. This would encourage compliance and ensure accurate information. Of course, this would not preclude the FAA from denying an application or suspending or revoking a medical certificate as appropriate after evaluating and determining the airman was medically not qualified.

Third, where appropriate, the FAA should establish a data-sharing program with the Social Security Administration (SSA) and/or other federal agencies. The FAA would provide other departments or agencies with a random sampling of airmen applications for cross checking. All federal agencies and departments involved in any related investigations of pilots must comply with all applicable federal laws, including those relating to personal and medical record privacy.

And fourth, AOPA will engage in a campaign to educate pilots regarding their responsibility to properly reporting medical issues on their medical applications. AOPA will also keep pilots updated on any changes in FAA policy or procedures. This education effort will focus on: Medical fraud and the existing penalties; the FAA Form 8500-8 including any new wording; data-sharing program with Social Security Administration; and any amnesty period for reporting previously unreported events (although pilots must follow FAA required procedures depending on issue reported).

AOPA Committed To Educating Pilots

The association will use all of its communication and staff resources in this campaign. These resources include:

- AOPA's Medical Certification staff;
- AOPA's TurboMedical interactive online tool;
- AOPA Web site (www.aopa.org), which received more than 80 million hits in 2006.
- AOPA *Pilot* magazine is a monthly publication mailed to more than 368,000 pilots, or more than 61% of the pilot population;
- AOPA *Flight Training* magazine is a monthly publication mailed to more than 114,000 pilots, or more than 18% of the pilot population; and,

- AOPA weekly newsletters are sent to more than 280,000 pilots, or more than 45% of the pilot population.

Thank you for the opportunity to testify on AOPA's four recommendations to address falsified pilot medical certificates. We look forward to working with the Subcommittee, the FAA, the pilots, and other interested groups to develop and implement concrete solutions.

Attachment A - AOPA Web site Resources

**AOPA's Pilot Information Center -
Medical Certification**

<http://www.aopa.org/members/pic/medical/certification/index.html>

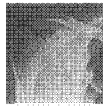
AOPA's Pilot Information Center Medical Certification

In this section, find answers to questions about how a medical condition might impact your flying privileges. Information is categorized by physiology and includes the relevant medical standards, as well as the procedures to follow for recertification, or to obtain a special issuance medical certificate.



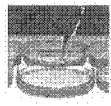
Introduction to the Airman Medical Certification Process

Find information on airman medical standards, special issuance medicals, AASIs, conditions warranting self-grounding, and more.



Bone and Joint

Includes information on arthritis and musculoskeletal conditions.



Cancer

Many pilots recover from cancer and regain flying privileges. Find out more here.



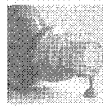
Ear, Nose, Throat, and Equilibrium

Read the medical standards for hearing, as well as information on cochlear implants, Eustachian bypass, and motion sickness.



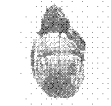
Endocrine System

Includes information on diabetes and thyroid conditions.



Gastrointestinal

GERD, hepatitis, colitis, Crohn's disease and more are covered here.



Heart and Circulatory System

Read how to get recertified after having heart-related problems.



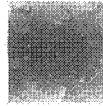
Immune System

HIV and related conditions are included in this section.



Mental Health

This section covers ADD/ADHD, depression, psychological evaluation, and substance abuse.



Neurological (Nervous System)

Read about migraine headaches, cerebrovascular disease, and strokes.

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[► The FAA and
Medications](#)

[► Medical Status
Request Form](#)

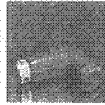
[► Flying Sport Pilot](#)

[► Frequently Asked
Questions](#)

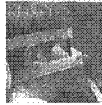
[► Medical Forms](#)

[► Additional Medical
Resources](#)

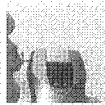
AOPA Online For Members - AOPA Pilot Information Center - Medical Certification

**Pulmonary**

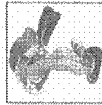
Read how you can keep your medical certification if you have asthma, allergies, or another lung-related condition.

**Sleep Disorders**

Find out what you'll need to do to get your medical renewed if you have sleep apnea.

**Substance Abuse**

Here are the guidelines for certification if you have a history of alcohol or drug-related problems.

**Urology (includes kidney)**

Read how to be recertified after having kidney stones removed, or after a successful kidney transplant.

**Vision**

Color vision, glaucoma, and LASIK surgery are all covered here.

Updated Tuesday, September 26, 2006 3:22:11 PM

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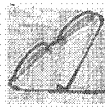
<http://www.aopa.org/members/plc/medical/certification/introduction/index.html>

AOPA's Pilot Information Center Medical Certification—Introduction to the Airman Medical Certification Process



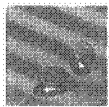
Overview

The *airman medical standards* are minimum standards. For that reason, the FAA develops certification policies that include baselines for different medical conditions.



First, Second, and Third Class Medical Certificates

The FAA issues three classes of medical certificates. Find out more here.



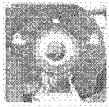
Comparison of Classes of Medical Standards

This table shows at a glance the differences among the three classes of medicals.



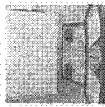
Special Issuance Medical Certification

There are 15 medical conditions that are specifically disqualifying, but you may be able to get a medical certificate under what's known as a special issuance authorization.



AASI Qualifying Conditions

The program, called AME Assisted Special Issuance (AASI), makes renewal easier for certain low-risk medical conditions.



Certification Tips

Find out how to minimize problems with the medical certification process.



Duration of Medical Certificate

How long is your medical certificate valid? Find out here.



FAR 61.53—Self-grounding for Medical Deficiency

What general medical conditions are grounding under the regulation, and for how long?

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[How/Where to Submit to the FAA](#)

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[Medical Status Request Form](#)

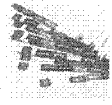
[Flying Sport Pilot](#)

[Frequently Asked Questions](#)

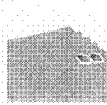
[Medical Forms](#)

[Additional Medical Resources](#)

AOPA Online For Members - AOPA Pilot Information Center - Medical Certification



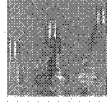
Following any surgery or hospitalization the FAA needs to see your medical records.



Helps you find the contact information for submitting your medical records.



SI Authorization Letter Interpretation
Read a sample letter of special issuance authorization that includes AOPA's explanation of what it means.



What Is a Status Report
Find out what your treating physician should include in a status report on your medical condition.

Updated Tuesday, September 26, 2006 3:24:34 PM

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Attachment B - AOPA's TurboMedical®

<http://www.aopa.org/members/pic/medical/turbomedical/index.html>

AOPA's Pilot Information Center

TurboMedical®: Know before you go what to expect at your next medical examination

TurboMedical® is an educational tool designed to be used as preparation for completing the actual FAA medical application before you report for an FAA physical examination.

Many pilots don't realize they may have a problem getting their medicals until they are faced with a questioning at the aviation medical examiner's office. Some medications are not acceptable to the FAA, and some reported conditions can require supporting documentation.



AOPA has developed this interactive medical application in an effort to help our members identify potential problems before the visit to the AME.

TurboMedical® asks the same questions as the FAA Form 8500-8, the application for Airman Medical Certificate (and Student Pilot Certificate) that you fill out to obtain and renew your medical certificate. By using this interactive form you can find out if a current medical condition, or prescription medication may be a problem with the FAA. It's better to know beforehand, so you can take appropriate actions before your doctor visit.

The **TurboMedical®** program presents the items on Form 8500-8 one at a time. As you answer each item, your answers are checked against acceptable FAA standards. If there is a problem (for instance, if you are taking a medication that the FAA will not approve), the program will tell you.

After you have finished completing the form, save your answers and print a copy. Take it with you to your appointment with your medical examiner. Your AME can now submit the hard copy of TurboMedical® as a substitute for the FAA 8500-8. You will need to sign the TurboMedical form in the presence of the AME or a member of the AME staff, and the front copy of the 8500-8 will be stapled to the TurboMedical® application and mailed to the FAA. If you have questions, please call the AOPA medical staff, 800-USA-AOPA (872-2672).



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Updated Tuesday, February 27, 2007 1:25:32 PM

Applicant Must Complete ALL 20 Items (Except For Shaded Areas) PLEASE PRINT Form Approved OMB NO. 2120-0034

UNITED STATES OF AMERICA Department of Transportation Federal Aviation Administration		TURBOMEDICAL® MEDICAL CERTIFICATE TURBOMEDICAL CLASS																																																																																					
This certifies that (Full name and address): AMERICAN AIRLINES The FAA is now accepting TurboMedical® form copy in place of the completed 8500-8 (see Federal Air Surgeon's Medical Bulletin, 2007-1, page 3, Certification Update)		1. Application For: <input checked="" type="checkbox"/> Airman Medical Certificate <input type="checkbox"/> Airman Medical and Student Pilot Certificate																																																																																					
2. Class of Medical Certificate Applied For: <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input checked="" type="checkbox"/> 3rd		3. Last Name: Hackman First Name: Robert Middle Name: Eugene																																																																																					
4. Social Security Number: 555 -- 55 -- 5555		5. Address: 421 Aviation Way																																																																																					
6. Date of Birth: 07/12/2004		7. Color of Hair: Gray 8. Color of Eyes: Blue 9. Sex: Male																																																																																					
10. Type of Airman Certificate(s) You Hold: <input type="checkbox"/> None <input type="checkbox"/> ATC Specialist <input checked="" type="checkbox"/> Flight Instructor <input type="checkbox"/> Recreational <input checked="" type="checkbox"/> Airline Transport <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Private <input type="checkbox"/> Other <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Navigator <input type="checkbox"/> Student		11. Occupation: Manager 12. Employer: Every Flight School																																																																																					
13. Has Your FAA Airman Medical Certificate Ever Been Denied, Suspended, or Revoked? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, give date: MM/DD/YYYY		14. Total Pilot Time (Civilian Only): 14. To Date: 3000 15. Past 6 months: 100 16. Date of Last FAA Medical Application: MM/DD/YYYY <input checked="" type="checkbox"/> No Prior Application																																																																																					
17.a. Do You Currently Use Any Medication (Prescription or Nonprescription)? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, below list medication(s) used and check appropriate box.)		17.b. Do You Ever Use Near Vision Contact Lenses While Flying? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																																																																					
18. Medical History - HAVE YOU EVER IN YOUR LIFE BEEN DIAGNOSED WITH, HAD, OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING? Answer "yes" or "no" for every condition listed below. In the EXPLANATIONS box below, you may note "PREVIOUSLY REPORTED, NO CHANGE" only if the explanation of the condition was reported on a previous application for an airman medical certificate and there has been no change in your condition. See Instructions Page.																																																																																							
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Conviction and/or Administrative Action History -- See Instructions Page																																																																																							
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19. Visits to Health Professional Within Last 3 Years. <input type="checkbox"/> Yes (Explain Below) <input checked="" type="checkbox"/> No See Instructions Page																																																																																							
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Date	Name, Address, and Type of Health Professional Consulted	Reason																																																																																					
<p>--- NOTICE ---</p> <p>Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious or fraudulent statements or representations, or omits, may be fined up to \$250,000 or imprisoned not more than 5 years, or both, (18 U.S.C. Code Secs. 1001; 3571).</p>																																																																																							
<p>20. Applicant's National Driver Register and Certifying Declarations</p> <p>I hereby authorize the National Driver Register (NDR), through a designated State Department of Motor Vehicles, to furnish to the FAA information pertaining to my driving record. This consent constitutes authorization for a single access to the information contained in the NDR to verify information provided in this application. Upon my request, the FAA shall make the information received from the NDR, if any, available for my review and written comment. Authority: 28 U.S.C. Code 401, Note.</p> <p>NOTE: ALL persons using this form must sign it. NDR consent, however, does not apply unless this form is used as an application for Medical Certificate or Medical Certificate and Student Pilot Certificate.</p> <p>I hereby certify that all statements and answers provided by me on this application form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for issuance of any FAA certificate to me. I have also read and understand the Privacy Act statement that accompanies this form.</p>																																																																																							
Signature of Applicant			Date: 08/08/2005 MM/DD/YYYY																																																																																				

Attachment C – September 2005 Letter to FAA



AIRCRAFT OWNERS AND PILOTS ASSOCIATION

421 Aviation Way • Frederick, MD 21701-4798
Telephone (301) 695-2000 • Fax (301) 695-2375
www.aopa.org

September 1, 2005

Jon L. Jordan, MD
Federal Air Surgeon
Office of Aerospace Medicine, AAM-1
800 Independence Avenue, SW
Washington, DC 20591

Dear Dr. Jordan:

With this letter, the Aircraft Owners and Pilots Association (AOPA) requests that the Federal Aviation Administration (FAA) amend its current medical application form to clearly disclose to airmen, that the information provided on the form can be accessed by other federal agencies, including the Social Security Administration (SSA), for law enforcement purposes. While the current application contains a vague Privacy Act disclosure statement, it lacks specificity. AOPA is advocating for a simple and direct statement as to how the Privacy Act applies to the individual.

This request stems from a recent law enforcement initiative that took place in Northern California. In July of 2003, the Department of Transportation Office of Inspector General (DOT-OIG) and Social Security Office of Inspector General (SSA-OIG), citing safety and security concerns, initiated a joint investigation to identify pilots misusing Social Security disability benefits.

While AOPA does not condone pilots who make false statements or omit known medical condition when applying for a medical certificate, we are very concerned that inadvertent or unintentional omissions during the medical application process could lead to unwarranted certificate actions or criminal charges.

For these reasons, it would be good public policy to revise the medical application to include more detailed information about the uses of the data that the airman provides, for reasons of overt fairness and avoidance of unintentional omissions.

Sincerely,

Luis M. Gutierrez
Director, Regulatory and Certification Policy



U.S. House of Representatives
Committee on Transportation and Infrastructure
 Washington, DC 20515

James L. Oberstar
 Chairman

David Heymefeld, Chief of Staff
 Ward W. McCarragher, Chief Counsel

John L. Mica
 Ranking Republican Member

James W. Coon II, Republican Chief of Staff

July 31, 2007

Mr. Phil Boyer
 President
 Aircraft Owners and Pilots Association
 421 Aviation Way
 Frederick, MD 21701

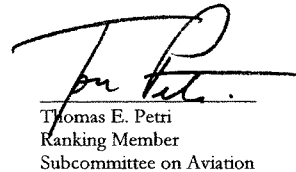
Dear Mr. Boyer:

On July 17, 2007, the Subcommittee on Aviation held a hearing on "FAA's Oversight of Falsified Airmen Medical Certificate Applications." Attached you will find additional questions that the Subcommittee would like you to answer.

I would appreciate your response within 14 days so that they may be included in the hearing record. Please send your response to: Leila Kahn, 586 Ford House Office Building, Washington, DC 20515. Due to delays in the receipt of mail in the mail screening process, I also request that you email and/or fax your response to Ms. Kahn at Leila.Kahn@mail.house.gov and (202) 226-6012. Should you have any questions or concerns, you may reach Ms. Kahn at (202) 226-4697.

Sincerely,


 Jerry F. Costello
 Chair
 Subcommittee on Aviation


 Thomas E. Petri
 Ranking Member
 Subcommittee on Aviation

AVIATION SUBCOMMITTEE HEARING ON "FAA'S OVERSIGHT OF FALSIFIED AIRMAN MEDICAL
CERTIFICATE APPLICATIONS"
QUESTIONS FOR THE RECORD
JULY 17, 2007

1. In your testimony you state, *where appropriate*, the FAA should establish a data-sharing program with the Social Security Administration and/or other federal agencies. What would you consider "appropriate"?
2. In a recent FAA survey, 15 percent of airmen reported that an AME did not review their medical history. Of those, nearly 80 percent said no medical history review was done at all. Another 4 percent reported that an AME did not conduct the physical exam. Of those responses, 13 percent said there was no physical exam. Have you done any similar survey of your members?
3. Do you have any sense of whether these findings are representative of the AME review process?
4. In your testimony, you suggest an online application, "TurboMedical" for medical certificates similar to the IRS tax software TurboTax. Could you please elaborate a little more on how TurboMedical works, how it could streamline the process, and when it could be implemented?
5. While intentionally lying on the form is a criminal act, I'm not interested in prosecuting pilots who make honest mistakes on their application form. What changes to the paper form does AOPA recommend to remove uncertainty and confusion from the form?
6. The FAA has proposed a rule-making that would extend the duration of first- and third-class medical certificates for individuals under the age of 40 to reflect a more appropriate interval for younger airmen. Do you support this regulatory action?



AIRCRAFT OWNERS AND PILOTS ASSOCIATION
421 Aviation Way • Frederick, Maryland 21701-4798
Telephone (301) 695-2020 • Fax (301) 695-2375
phil.boyer@aopa.org

Phil Boyer
President

August 10, 2007

The Honorable Jerry F. Costello
Chairman
Subcommittee on Aviation
U.S. House of Representatives
Washington, DC 20515

Jerry
Chairman Costello:

Thank you for the opportunity to testify at the Subcommittee on Aviation's July 17, 2007 hearing regarding the "FAA's Oversight of Falsified Airmen Medical Certificate Applications." In the interest of safety, the Aircraft Owners and Pilots Association (AOPA) supports the Committee's efforts to ensure that pilots adhere to Federal Aviation Administration (FAA) medical standards.

Please find attached, answers to the questions that the Subcommittee sent to AOPA on July 31, 2007. I trust that these answers will help the Committee in addressing this important issue.

Sincerely,

Phil Boyer

Attachment

*one down!
next Flight Service!*

Aircraft Owners and Pilots Association (AOPA) Response to Additional Questions from House Aviation Subcommittee July 17, 2007 Hearing on FAA's Oversight of Falsified Airmen Medical Certificate Applications

- 1. Subcommittee Question: In your testimony you state, *where appropriate*, the FAA should establish a data-sharing program with the Social Security Administration and/or other federal agencies. What would you consider "appropriate"?**

AOPA Reply: "Where appropriate" refers to the principle that the information collected by any data-sharing program is legal under existing state and federal laws. Also important, is collection of the information that could *not* be obtained through the already existing medical certification process, and it provides useful and necessary information that would have a *direct bearing* on the issuance of an FAA medical certificate.

Paramount in any data-sharing program is properly notifying the medical certificate applicant that the data will be shared.

- 2. In a recent FAA survey, 15 percent of airman reported that an AME did not review their medical history. Of those, nearly 80 percent said no medical history review was done at all. Another 4 percent reported that an AME did not conduct the physical exam. Of those responses, 13 percent said there was no physical exam. Have you done any similar survey of your members?**

AOPA Reply: Our association has not conducted any surveys that directly ask about the AME's review of the applicant's medical history or the physical exam. However, based on AOPA's experience in handling approximately 30,000 pilot medical inquiries each year and assisting more than 2,000 pilots through the medical special issuance process annually, it is clear pilots are receiving a physical exam and an AME review of their medical history.

- 3. Subcommittee Question: Do you have any sense of whether these findings are representative of the AME review process?**

AOPA Reply: Given the feedback the association receives from pilots seeking FAA medical certification, these survey findings are surprising. Pilot feedback to AOPA indicates that pilots take the medical certification process very seriously and work to ensure that they are meeting the regulatory requirements of the FAA, including receiving a proper review of their medical history by an AME.

- 4. Subcommittee Question: In your testimony, you suggest an online application, "TurboMedical" for medical certificates similar to the IRS tax software TurboTax. Could you please elaborate a little more on how TurboMedical works, how it could streamline the process, and when it could be implemented?**

AOPA Reply: Developed in 2001, AOPA's TurboMedical was designed to help pilots fully understand the FAA's medical regulatory requirements and comply with the Federal Aviation Regulation certification process.

TurboMedical does this by covering the same questions as the FAA Form 8500-8, that a pilot would fill out to obtain or renew their FAA medical certificate. The AOPA TurboMedical program presents the items on Form 8500-8 one at a time. As the medical applicant answers each item, the answers are checked against the acceptable FAA standards. The program flags any answers that would require follow-up or additional information from the pilot's treating physician. By completing TurboMedical prior to the FAA physical examination, the applicant knows if any additional documentation is needed and will have time to obtain that information before the medical exam. The applicant can also save their answers and bring a printed copy of the TurboMedical form to their AME.

The FAA has developed its own online medical application called MedXPress. The two big differences between MedXPress and TurboMedical are that the MedXPress form can be submitted online (no paper copies are necessary) and MedXPress does not identify medical conditions that require additional documentation from the applicant.

It is important that pilots be permitted to file AOPA TurboMedical forms electronically with the FAA, as is currently allowed with MedXPress. Doing so would increase the number of complete medical packets presented to the AME at the time of the physical, thus decreasing the processing time for pilots with medical conditions that require supporting documentation from their treating physicians.

- 5. Subcommittee Question: While intentionally lying on the form is a criminal act, I'm not interested in prosecuting pilots who make honest mistakes on their application form. What changes to the paper form does AOPA recommend to remove uncertainty and confusion from the form?**

AOPA Reply: The questions listed in Area 18 of the medical application form, titled "Medical History", should be better defined to remove any ambiguity from the questions. Currently, some of these questions could be interpreted to include both minor and major medical conditions. For example, question 18 C, asks "Have you ever in your life

been... unconscious for any reason?" If an applicant was administered anesthesia during wisdom teeth removal should they check "yes" to this question because technically they were unconscious? Or does this question only apply to a sudden, unanticipated episode of unconsciousness? While the TurboMedical program guides pilots through these questions, rewording Area 18 would help the pilot community better understand what they are being asked to report.

The medical application form should be modified to alert pilots that the information provided on the form could be shared with other government agencies such as the Social Security Administration. The instructions and statements in Area 20 should be modified to include language about this possible information sharing. The inclusion of this warning statement should be similar to the existing statement regarding the National Driver Registry cross check and must be displayed in a prominent location on the form.

Lastly, the "Notice" section of the medical application, which discusses the possible penalties for knowingly making false statements on the form, should be relocated to the top of the form and the size of the text should be enlarged. These changes will give this section more prominence and make it more obvious to applicants.

6. Subcommittee Question: The FAA has proposed a rule making that would extend the duration of first- and third-class medical certificates for individuals under the age of 40 to reflect a more appropriate interval for younger airmen. Do you support this regulatory action?

AOPA Reply: AOPA supports the extension of the duration of the first- and third-class medical certificates and stated so in comments submitted on June 11, 2007 to the FAA's Notice of Proposed Rulemaking (Docket No. FAA-2007-27812). The extended duration would only be valid until the pilot reached their fortieth-birthday. The FAA should expand the scope of the proposed change based on an analysis of the age 40 break point.

An analysis of the AOPA Air Safety Foundation's Accident and Incident database reveals that an extremely low number, 1.9 percent, of accidents had any medical factors contributing to the accident, and the accidents caused by medical incapacitation were not attributable to conditions that could have been identified or predicted by an FAA physical examination.

National Transportation Safety Board

**490 L'Enfant Plaza, SW
Washington, D.C. 20594
(202) 314-6000**



**Mitchell A. Garber
Medical Officer**

Testimony of
Mitchell A. Garber, M.D., M.P.H., M.S.M.E.
Medical Officer
National Transportation Safety Board
before the
Committee on Transportation and Infrastructure
Subcommittee on Aviation
U.S. House of Representatives
“FAA’s Oversight of Falsified Airman Medical Certificate Applications”
July 17, 2007

Good morning Chairman Costello, Ranking Member Petri, and Members of the Subcommittee. Thank you for allowing me the opportunity to present testimony on behalf of the National Transportation Safety Board regarding FAA’s Oversight of Falsified Airman Medical Certificate Applications. It is a privilege to represent an agency that is dedicated to the safety of the traveling public.

On June 17, 2002, a commercial-rated pilot performing wolf survey flights under contract to the Michigan Department of Natural Resources descended at high speed into terrain. Examination of the wreckage revealed no anomalies. The pilot had multiple serious medical conditions, including coronary heart disease requiring angioplasty and bypass surgery, disease of his heart valves, congestive heart failure, abnormal heart rhythms and diabetes requiring insulin and oral medication. The pilot and his personal physician--who had flown the pilot back from his hospitalization following his initial heart attack and who later became his Aviation Medical Examiner (AME) for many years--had concealed from the Federal Aviation Administration (FAA) information regarding the pilot's conditions on seven applications for Airman Medical Certificates. The pilot's physician had denied knowing the pilot when the FAA was investigating a report that the physician was treating him for these conditions. At the time of the accident, the pilot's physician had been decertified as an AME for failure to complete required training, and the pilot did not have a current medical certificate, having been deferred for certification by a new AME who noted some abnormal heart rhythms on examination. The Safety Board concluded that the accident was caused by the incapacitation of the pilot and that a contributing factor was the pilot and his physician providing false information on the pilot's medical applications

I would like to review some data regarding the extent to which we see issues such as these in our investigations. A recent staff review of over 20,000 aviation accidents investigated since 1995 found 327 in which impairment, incapacitation, or a medical condition were identified as causes or factors:

- 61 involved over-the-counter medications, primarily antihistamines like diphenhydramine, also commonly known by the trade name Benadryl;

- 84 involved prescription medications (primarily anti-anxiety medications, painkillers, and a few older antidepressant medications and anti-psychotic medications);
- 52 involved illicit substances and 73 involved alcohol;
- 106 involved some sort of identified or suspected medical condition; of these –
 1. 15 had no current medical certificate (2 were gliders and none was required);
 2. In 13 with a current medical certificate, it was established that the pilot was not aware of the condition;
 3. In 38 with a current medical certificate, it was not established that the pilot was either aware or unaware of symptoms of the condition prior to the flight (this includes 21 accidents attributed to an acute condition – heart attack, stroke, gastrointestinal distress, etc.);
 4. In 40 with a current medical certificate, it was established that the pilot was aware of the condition:
 - In 10 of these, the condition had been fully reported to the FAA;
 - In 26 of these, the pilots had either not reported any information or had reported incomplete information regarding their condition to the FAA at the time of their most recent medical certificate.

It is important to note that these numbers are certainly an underestimate of the extent to which this issue is involved in accidents. The NTSB judiciously uses its subpoena authority to obtain personal medical records only when evidence already exists--usually from autopsy or toxicology reports or from the nature of the accident--to suggest medical involvement. In many cases, there is insufficient evidence available to completely evaluate the possibility of impairment or incapacitation.

The NTSB is fortunate to benefit from the resources of the FAA toxicology laboratory at the Civil Aerospace Medical Institute, likely the finest toxicology laboratory in the world for analysis of specimens from accident investigations. We are, therefore, confident that we are finding most reasonably detectable medications and other drugs of relevance in samples submitted to the laboratory, and we are often able to determine that the pilot used a specific substance in the hours or days preceding the accident.

It is our experience, confirmed by FAA studies, that most medications found on toxicology evaluation, even those routinely approved by the FAA for use by pilots, are not reported on the most recent applications for airman medical certificates of accident-involved pilots. It is frequently not possible to definitively determine when these medications were started, or what the condition was for which they were taken. Based on the cases in which such determinations could be made, however, it seems likely that the use of many if not most of these

medications was concealed from the FAA. In most cases, the medications themselves are unlikely to have impaired the pilot, and were not determined to be related to the cause of the accident.

Though it was not possible in most cases to determine the reasons for which medications were used, the medications that were found to be relevant to accident causes were most frequently those commonly utilized for the relatively short-term treatment of conditions such as allergy symptoms, anxiety, and pain.

In a number of cases, potentially addictive prescription medications were found at levels well in excess of normal therapeutic concentrations, strongly suggesting the possibility of substance dependence. Alcohol and illicit substances are also found in more than a third of the accidents deemed to result from impairment or incapacitation. The alcohol levels in alcohol-involved accidents are most commonly many times higher than the FAA's limit for operating an aircraft, strongly suggesting the possibility of alcohol dependence in most alcohol-involved accidents. The NTSB has identified a number of alcohol or illicit substance related accidents in which prior evidence of substance dependence was available to the FAA.

The Safety Board notes that it is, of course, possible for a pilot to fly without medical certification, as was the case for the pilot in the accident presented, even though he was being employed by a State agency at the time of his accident. Ramp checks on pilots not involved in commercial passenger operations are infrequent, and FAA inspectors have limited authority to physically enforce flight restrictions at any rate. Pilots under many circumstances, such as balloon pilots, glider pilots, and now sport pilots, are able to fly without obtaining a medical certificate.

The Safety Board also notes that it is often difficult, even with the Board's investigative authority, to definitively identify cases of falsification on application for medical certificates. It is necessary to first identify the existence of a condition or medication, establish that it would have resulted in substantially different answers on the pilot's most recent application for medical certificates, and prove that the condition or medication was present at the time of the most recent application, as there is no requirement for reporting such conditions or medications in between examinations.

The FAA permits anonymous reporting of medical conditions in pilots and frequently conducts independent investigations of such reports, as in the case for the accident presented. As noted for this case, however, it is still possible for the condition to be concealed, particularly when a physician can be persuaded to lie on behalf of the pilot. Even when the FAA becomes aware of such falsification, action is frequently limited to the revocation of certifications issued, rather than criminal prosecution, for which resources are not always available.

The Safety Board has been concerned for many years regarding the inappropriate use of certain medications by pilots and other vehicle operators, and in 2000 issued comprehensive recommendations on this topic to the Department of Transportation (DOT), the Food and Drug Administration (FDA) and modal agencies to improve information provided to such operators regarding the use of appropriate medications while engaged in vehicle operations (including

I-00-1 through -5 and A-00-4 through -6). Although some modal agencies have taken certain responsive actions, the overall response to date from the DOT and the FDA has been limited and the majority of the recommendations on this topic have not been implemented.

The Safety Board has also noted that in many accidents due to a pilot's intoxication by alcohol, illicit substances, or large amounts of potentially addictive medications, the FAA was or should have been aware of information that would have led them to conclude that the pilot was substance dependent and would have restricted issuance of a medical certificate. In particular, the NTSB has noted a number of instances in which the FAA did not request details from identified DUI convictions in order to determine the circumstances of the violations. Additionally, the Board has found that information available to the FAA on potentially substance dependent pilots was often not provided to individuals evaluating the pilots for possible substance dependence. Furthermore, the Board is concerned that, unlike other chronic conditions, the FAA does not routinely require that pilots with substance dependence be followed for the condition for the period that they hold a medical certificate. The Board has recently issued several recommendations (A-07-41 to -43) to address these deficiencies.

Finally, the Safety Board notes that, unlike many other countries, and inconsistent with International Civil Aviation Organization recommendations, there is no requirement for the reporting of medical conditions in between periodic examinations. As noted previously in this testimony, this significantly increases the complexity of establishing that a condition was concealed from the FAA, since it may not have become apparent until after the most recent medical examination. The FAA has recently proposed increasing the interval between medical examinations for certain pilots, and the Safety Board has noted in its comments to that NPRM that a reporting requirement between examinations would be desirable.

This concludes my prepared statement and I will be happy to answer any questions.



U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

John L. Mica
Ranking Republican Member

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

July 31, 2007

James W. Coon II, Republican Chief of Staff

Dr. Mitchell A. Garber, M.D., M.P.H., M.S.M.E.
Medical Officer
National Transportation Safety Board
490 L'Enfant Plaza East
Washington, D.C. 20594


Dear Dr. Garber:

On July 17, 2007, the Subcommittee on Aviation held a hearing on "FAA's Oversight of Falsified Airmen Medical Certificate Applications." Attached you will find additional questions that the Subcommittee would like you to answer.

I would appreciate your response within 14 days so that they may be included in the hearing record. Please send your response to: Leila Kahn, 586 Ford House Office Building, Washington, DC 20515. Due to delays in the receipt of mail in the mail screening process, I also request that you email and/or fax your response to Ms. Kahn at Leila.Kahn@mail.house.gov and (202) 226-6012. Should you have any questions or concerns, you may reach Ms. Kahn at (202) 226-4697.

Sincerely,


Jerry F. Costello
Chair
Subcommittee on Aviation


Thomas E. Petri
Ranking Member
Subcommittee on Aviation

**AVIATION SUBCOMMITTEE HEARING ON "FAA'S OVERSIGHT OF FALSIFIED AIRMAN MEDICAL
CERTIFICATE APPLICATIONS"
QUESTIONS FOR THE RECORD
JULY 17, 2007**

1. A history or clinical diagnosis of substance dependence is specifically disqualifying for airmen duties. Why is this? Shouldn't it only matter if the pilot is operating an aircraft while under the influence?
2. The NTSB has issued comprehensive recommendations to the Department of Transportation concerning the inappropriate use of certain medications by pilots. What are these medications and why do you believe they are inappropriate?
3. What has FAA's response to these recommendations been?
4. What is the level of risk posed by the falsification of airman medical certificate applications relative to other aviation safety risks, for instance those risks identified on the Most Wanted List?
5. The FAA has proposed a rule-making that would extend the duration of first- and third-class medical certificates for individuals under the age of 40 to reflect a more appropriate interval for younger airmen. Does the accident data you see justify this change? Do younger pilots have fewer health risks, and therefore, pose less of a safety risk as a result?

**QUESTIONS FOR THE RECORD
AVIATION SUBCOMMITTEE
TRANSPORTATION AND INFRASTRUCTURE COMMITTEE
"FAA's OVERSIGHT OF FALSIFIED AIRMEN MEDICAL
CERTIFICATE APPLICATIONS"
JULY 17, 2007**

QUESTION: A history or clinical diagnosis of substance dependence is specifically disqualifying for airmen duties. Why is this? Shouldn't it only matter if the pilot is operating an aircraft while under the influence?

RESPONSE: This is most appropriately a question for the Federal Aviation Administration (FAA) as they maintain the regulatory basis for disqualifying conditions. However, since the National Transportation Safety Board has recently issued recommendations regarding substance dependence as a disqualifying condition, this answer lays out the Safety Board's position on that particular condition (additional details provided in the attached June 25, 2007 recommendation letter). Substance dependence, like heart disease, diabetes, or other disqualifying conditions, is a chronic condition which requires lifelong treatment. Without such treatment, the risk of relapse is high, and a pilot with substance dependence may suddenly resume use of impairing substances (resulting in an elevated risk of operating an aircraft either while impaired by the substance or while impaired by withdrawal from the substance). That is not to suggest that pilots diagnosed with substance dependence should never be permitted to operate aircraft, only that such operation be contingent on appropriate treatment and follow-up, as with other disqualifying conditions.

QUESTION: The NTSB has issued comprehensive recommendations to the Department of Transportation concerning the inappropriate use of certain medications by pilots. What are these medications and why do you believe they are inappropriate?

RESPONSE: The Safety Board has recommended that the Department of Transportation (DOT) establish a list of medications that would be permitted for use by transportation operators (January 13, 2000 recommendation letter attached). This recommendation is based on the substantial number of accidents in which the use of a legal medication has been found to be causal or contributory. The Safety Board has found a wide variety of prescription and over-the-counter medications in its accident investigations; the majority of those determined to have contributed to accidents have been anti-anxiety medications, painkillers, a few antidepressant medications, and a number of over-the-counter antihistamines. To date, the DOT has not established an approved medication list nor indicated substantive interest in the establishment of such a list.

QUESTION: What has FAA's response to these recommendations been?

RESPONSE: The Safety Board's recommendations to the FAA were to establish criteria by which medications not on the DOT's approved list could, where appropriate, be used by airmen, and to develop and disseminate information on the hazards of using specific medications while flying. The FAA has taken action to develop information for use by pilots regarding medication use, but cannot take action regarding the DOT's list until such a list is in fact developed by the DOT.

QUESTION: What is the level of risk posed by the falsification of airmen medical certificate applications relative to other aviation safety risks, for instance those risks identified on the Most Wanted List?

RESPONSE: The Safety Board has noted in its testimony that a review of over 20,000 aviation accidents investigated since 1995 definitively identified 26 accidents that were due to deliberate falsification of airman medical certificate applications. Our testimony also noted that this number is certainly an underestimate of the extent of such involvement, as resource and data limitations prevent the complete identification of all accidents in which undisclosed medical conditions may have played a role, though the Safety Board makes every effort to collect appropriate medical information when autopsy, toxicology, or other evidence suggests a medical cause to an accident.

QUESTION: The FAA has proposed a rule-making that would extend the duration of first- and third-class medical certificates for individuals under the age of 40 to reflect a more appropriate interval for younger airmen. Does the accident data you see justify this change? Do younger pilots have fewer health risks, and therefore, pose less of a safety risk as a result?

RESPONSE: The Safety Board has submitted comments to the FAA's rulemaking in this regard (June 12, 2007 letter attached for more details). The extension of the duration of medical certificates may be appropriate, so long as certain critical issues noted in Safety Board's comments are addressed:

- Though many medical conditions are more likely to become apparent as pilots age, substance dependence is most likely to first result in symptoms in younger pilots. National Driver Registry (NDR) inquiries, currently performed in conjunction with pilot applications for medical certificates, may be considerably less effective at detecting possible evidence of substance abuse and dependence disorders if the interval between such inquiries is extended; it is therefore critical that the NPRM require policy changes to ensure an appropriate frequency of NDR database evaluations that is no less than currently performed
- The NPRM, if adopted, will increase the time between the discovery of a new medical condition and the required reporting of that condition on a pilot's application for a medical certificate. The Safety Board believes that the proposed rule should follow the International Civil Aviation Organization and European Joint Aviation Authorities

Aug-08-07 10:23am From-NTSB

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F-808

guidelines and require that potentially disqualifying conditions be reported to the FAA in a timely fashion.



National Transportation Safety Board
Washington, D.C. 20594

Safety Recommendation

Date: June 25, 2007

In reply refer to: A-07-41 through A-07-43

Honorable Marion C. Blakey
Administrator
Federal Aviation Administration
Washington, DC 20591

The National Transportation Safety Board has investigated a number of aircraft accidents in which the Federal Aviation Administration (FAA) had information to indicate, and was or should have been aware, that the pilot had a history of substance dependence, and in which the pilot's substance dependence was relevant to the cause of the accident. As a result of such investigations, the Safety Board is recommending several changes in policy regarding the evaluation of airmen with a known or suspected history of substance dependence.

Records of Offenses

The FAA defines substance dependence (including alcohol dependence) as "evidenced by (A) increased tolerance, (B) manifestation of withdrawal symptoms, (C) impaired control of use, or (D) continued use despite damage to physical health or impairment of social, personal, or occupational functioning" [14 *Code of Federal Regulations* (CFR) 67.107(a)(4)(ii), 67.207(a)(4)(ii), and 67.307(a)(4)(ii)]. A history or clinical diagnosis of substance dependence is specifically disqualifying for airmen duties, except under certain circumstances described later in this letter. The FAA requires that airmen report a history of substance dependence (including alcohol dependence) on each Application for Airman Medical Certificate. The FAA also requires that airmen report any convictions involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug and any convictions or administrative actions resulting in the denial, suspension, cancellation, or revocation of driving privileges or resulting in attendance at an educational or a rehabilitation program; the FAA also performs a National Driver Register (NDR) inquiry to verify that all relevant convictions are in fact reported. The FAA does *not*, however, routinely obtain arrest reports or court records for drug or alcohol-related offenses identified through required self-reporting or through routine NDR searches, and details regarding the circumstances of the offense(s), including blood alcohol and driver behavior at the time of the offense, are not included in the NDR database. Such details are generally provided by the pilot and are not always verified by the FAA. As with other symptoms that may indicate serious disease (for example, chest pain as a symptom of coronary artery disease), objective details of such offenses may be necessary to determine if an offense is a symptom of substance dependence.

For example, in a recent accident investigated by the Safety Board,¹ the pilot had previously reported a DUI conviction to the FAA, but the FAA did not obtain records of that offense. The Safety Board subsequently obtained the arrest records, which noted that the pilot had a blood alcohol level of 0.28 percent more than an hour after his traffic stop. The records also detailed that the pilot had been actively controlling his vehicle, was completely conscious, and was conversing with the arresting officer. At a blood alcohol level of 0.28 percent, non-tolerant individuals would be unconscious or nearly so.² The fact that the pilot was able to operate a vehicle at a level even greater than 0.28 percent (his blood alcohol level would have dropped from the time of the traffic stop to the time of the blood alcohol testing) is evidence of tolerance; this pilot would have met the FAA's definition for substance dependence. As a result, this pilot would not have been issued a medical certificate, had the FAA considered the DUI arrest record as part of the medical certification application process.

As noted in the Safety Board's 2000 Safety Report, *Actions to Reduce Fatalities, Injuries, and Crashes Involving the Hard Core Drinking Driver*, data reviewed by the National Highway Traffic Safety Administration suggest that the risk of arrest for driving while impaired varies from 1 in 300 to 1 in 2,000 impaired driving trips.³ It is therefore likely that an individual with a recent conviction reported in the NDR has a history of multiple instances of driving impaired. In addition, the Board report notes that in many cases, drivers arrested for impaired driving are not convicted of an impaired driving offense.

Thus, a pilot convicted of even a single traffic offense involving alcohol or drugs is reasonably likely to have driven impaired on a large number of occasions and may be substance dependent. Knowing the circumstances of such an offense will typically be extremely helpful in determining substance dependence accurately and in making a suitable decision about the pilot's continued medical certification. In addition, because police routinely query databases in addition to the NDR during a DUI arrest, arrest records will often include information on prior substance-related arrests and convictions that may not be included in the NDR because many states limit the information available through the NDR to the most recent 3 years or because administrative action has been taken in lieu of a conviction. Court records relating to reportable convictions or administrative actions will also often provide such additional information, even if such judicial actions were taken in the absence of an arrest and therefore no arrest records were available. Failure to require pilots to routinely provide such records hinders the FAA in accurately establishing a diagnosis of substance dependence. In contrast, the FAA routinely requires pilots potentially diagnosed with other chronic diseases to provide detailed records and often requires original media (such as coronary angiography films in the evaluation of coronary heart disease) to ensure an objective assessment of the pilot's condition. The Safety Board therefore

¹ See the Safety Board Aviation Accident Database at <http://www.ntsb.gov/ntsb/query.asp>: Bullhead City, Arizona, July 23, 2006, NTSB accident number LAX06FA243.

² See, for instance, M. A. Schuckit, Chapter 372, "Alcohol and Alcoholism," in *Harrison's Principles of Internal Medicine*, 16th edition (D. L. Kasper, E. Braunwald, A. S. Fauci, S. L. Hauser, D. L. Longo, J. L. Jameson, and K. J. Isselbacher, eds.) (New York, McGraw-Hill Professional, 2005).

³ National Highway Traffic Safety Administration, *Alcohol and Highway Safety 1984: A Review of the State of the Knowledge* (Washington: National Highway Traffic Safety Administration), 56.

recommends that the FAA ensure that any airman undergoing aeromedical evaluation following a traffic conviction or administrative action that is required to be reported in the FAA Application for Airman Medical Certificate, form 8500-8, item 18v, is required to provide a complete copy of the relevant arrest report and/or court records, and that those records are placed in the airman's FAA medical file prior to clinical evaluation for certification.

Records for Evaluators

The FAA requires Aviation Medical Examiners (AMEs) to defer the issuance of a medical certificate for pilots with a history of substance dependence or abuse.⁴ Pilots with a history of substance dependence or abuse who desire certification are required to submit to the FAA a current status report from a physician certified in addictive disorders and familiar with aviation standards. This report is a critical part of the FAA determination as to whether the pilot may retain or regain a medical certificate. The physicians generating such reports are not, however, routinely provided a copy of an airman's complete FAA medical record on file in the Aerospace Medical Certification Division, and therefore are entirely dependent upon the airman themselves for providing details of their medical and/or legal history with regards to substance use. In addition, airmen with potentially disqualifying medical conditions may present those conditions in the most favorable light and may not provide evaluators with critical objective information regarding their substance use or abuse.

For example, in the investigation of a 14 CFR Part 135 accident due in part to the airline transport-rated pilot's impairment from cocaine,⁵ the Safety Board found that the pilot had previously undergone a psychiatric evaluation in which he had indicated a history of incarceration for marijuana use only; the psychiatrist performing the evaluation concluded that the pilot could maintain his FAA license. However, the FAA medical records noted that the pilot had a cocaine habit and had been jailed for over 4 years following a conviction for distribution of 8 ounces of cocaine; this information was apparently not available to the psychiatrist performing the evaluation. Similarly, in another 14 CFR Part 135 accident a few years later,⁶ due in part to another airline transport-rated pilot's impairment (from alcohol and cocaine), the Board found that the pilot had previously undergone a neuropsychology evaluation in which he had specifically denied any history of alcohol abuse, and the neuropsychologist performing the evaluation concluded that the pilot's prognosis was quite good. However, an outpatient treatment center discharge summary (preceding the neuropsychology evaluation) contained in

⁴ "Substance abuse" is considered disqualifying by the FAA if it occurs within the previous 2 years, and is defined by the FAA as the use of a substance more than once in a situation in which that use was physically hazardous, a verified positive or refusal to submit to a Department of Transportation drug or alcohol test, or misuse of a substance that the Federal Air Surgeon finds makes it unsafe to perform the duties or exercise the privileges of an individual's airman certificate (14 CFR 67.107(b), 67.207(b), and 67.307(b)). In many cases, substance abuse is a symptom of substance dependence.

⁵ See the Safety Board Aviation Accident Database at <http://www.ntsb.gov/ntsb/query.asp>: Unalaska, Alaska, January 23, 2001, NTSB accident number ANC01FA033.

⁶ See the Safety Board Aviation Accident Database at <http://www.ntsb.gov/ntsb/query.asp>: June 14, 2004, Kodiak, Alaska, NTSB accident number ANC04FA063.

the FAA medical records noted that the pilot was "assessed as alcohol/cocaine abusive" and that "[h]is secondary issues include ... denial - minimization of alcohol abuse...."

The FAA's requirement for specialist evaluation of those pilots suspected of substance dependence is consistent with Safety Board recommendation A-88-35, which was issued in part "since substance abuse detection is difficult and frequently complicated by an abuser's denial."⁷ Given the possibility of such denial, the Safety Board believes that specialists evaluating substance use in pilots should have the benefit of all the objective information available. The Safety Board therefore recommends that, as is currently done for certain other consulting specialists, the FAA provide a copy of an airman's complete medical record (including relevant arrest and court records) on file in the Aerospace Medical Certification Division to any individual performing a clinical evaluation of that airman related to the airman's application for a medical certificate for the purpose of establishing, ruling out, or monitoring a history or diagnosis of substance dependence (including dependence on alcohol), as defined in 14 CFR 67.107(a)(4)(ii), 67.207(a)(4)(ii), and 67.307(a)(4)(ii), prior to the completion of such an evaluation.

Special Issuance

As noted above, a history or clinical diagnosis of substance dependence is defined in 14 CFR 67.107(a)(4), 67.207(a)(4), and 67.307(a)(4) as disqualifying for airman duties. For airmen who do not meet the regulatory criteria for medical certification for any reason, including substance dependence, the FAA may permit certification under a time-limited Authorization for Special Issuance (14 CFR 67.401). Before each such authorization or re-authorization, airmen must show evidence that the public is not endangered if they perform the duties permitted under the certificate. For every diagnosed disqualifying chronic condition *except* substance dependence (for example, myocardial infarction, insulin-treated diabetes, coronary heart disease, and epilepsy), airmen must be followed under guidelines for special issuance for as long as they hold such certificates.

In contrast with regulations governing all other disqualifying chronic diseases, current regulations permit an airman with a history or diagnosis of substance dependence to be certified *without* Authorization for Special Issuance "where there is established clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence from the substance(s) for not less than the preceding 2 years."⁸ Under such certification, an airman

⁷ Recommendation A-88-35 was classified "Closed—Acceptable Alternate Action," on November 5, 1990, based on provisions for the FAA "to provide screening for alcohol- and drug-related motor vehicle convictions rather than relying on the commercial operator as outlined in the recommendations." It asked the FAA to "[r]equire that all pilots identified as convicted substance abusers be medically examined and evaluated by a person qualified in the field of substance abuse detection and treatment to verify compliance with the medical certification requirements of 14 CFR Part 67.

⁸ Title 14 CFR §§ 67.107(a)(4), 67.207(a)(4), 67.307(a)(4). The Safety Board recognizes that the FAA's enactment of this standard was the result of the Ninth Circuit's application of the Hughes Act to the FAA's regulation regarding medical certification. *Jensen v. FAA*, 641 F.2d 797 (9th Cir. 1981); see also 47 *Federal Register* 16,303 (Apr. 15, 1982) (quoting the Hughes Act, which stated, "[n]o person may be denied or deprived of Federal, civilian

with a diagnosis of substance dependence may never receive additional medical follow-up from the FAA.

For example, in the investigation of a general aviation accident due in part to the private pilot's impairment from alcohol,⁹ the Safety Board found that the pilot's FAA medical records indicated a diagnosis of alcohol dependence with a high risk of relapse. According to those records, after several years of abstinence, the pilot was granted a third-class medical certificate without Authorization for Special Issuance or any additional follow-up, in spite of information provided by the pilot's internist 3 years later (in response to a request for information on an unrelated medical condition) indicating that the pilot continued to drink. Similarly, in another general aviation accident due in part to the private pilot's impairment from alcohol,¹⁰ the Board found that the pilot's FAA medical records indicated a history of alcohol dependence with at least 3 failed treatments (relapsing once while attempting to regain his medical certificate after 3 years of sobriety). The pilot's medical records also showed an FAA decision to grant a second-class medical certificate without Authorization for Special Issuance or any additional follow-up, in spite of a false application (noting no history of alcohol dependence or abuse) for a second-class airman medical certificate less than 8 months before the accident. Under current FAA regulations and practice, even pilots who have been previously certified under Authorization for Special Issuance for substance dependence may be subsequently certified *without* such authorization if they submit evidence of 2 years of abstinence.

Many common approaches to treatment (Alcoholics Anonymous, the Minnesota Model, and the Human Intervention Motivation Study) consider chemical addiction as a primary, chronic, and progressive disease, and include complete abstinence as a goal of treatment. In treated professional populations with substance dependence disorders, relapse is fairly common, even after prolonged periods of abstinence.¹¹ For this reason, prolonged follow-up is typical for programs treating substance-dependent populations. Because substance dependence is generally considered a lifelong disorder, pilots with such a history, like those with all other specifically disqualifying chronic diseases, should be continuously re-evaluated to ensure that their flying does not create unacceptable risk. The Safety Board therefore recommends that the FAA require

or other employment or a Federal professional or other license or right solely on the grounds of prior alcohol abuse or prior alcoholism." The Safety Board considers neither the *Jensen* opinion nor the Hughes Act to preclude the enactment of revised medical certificate standards for airmen with a history of alcohol abuse; since *Jensen*, Congress has recodified the Hughes Act and omitted the provision that the FAA cited at 47 *Federal Register* 16,303 (Apr. 15, 1982) (quoted above). See Alcohol and Drug Abuse Amendments of 1983, Public Law No. 98-24, 97 Stat. 175 (1983); S. Rep. No. 98-29 (1983).

⁹ See the Safety Board Aviation Accident Database at <http://www.ntsb.gov/ntsb/query.asp>; Angela, Montana, August 18, 2004, NTSB accident number SEA04LA168.

¹⁰ See the Safety Board Aviation Accident Database at <http://www.ntsb.gov/ntsb/query.asp>; Milwaukee, Wisconsin, November 12, 2005, NTSB accident number CHI06LA031.

¹¹ See, for instance, (a) G. Lloyd, "One Hundred Alcoholic Doctors: A 21-Year Follow-Up," *Alcohol and Alcoholism*, Vol. 34, No. 2 (2002): 370-4, in which at least 11% of alcohol-dependent physicians who had been in recovery for over 10 years subsequently relapsed; and (b) K. B. Domino and others, "Risk Factors for Relapse in Health Care Professionals with Substance Use Disorders," *JAMA*, Vol. 293, No. 12 (2005): 1453-60, in which 25 percent of physicians enrolled in a substance use treatment program relapsed, 13% suffering a first relapse after more than 5 years in the program.

that all airmen clinically diagnosed with substance dependence (including dependence on alcohol), as defined in 14 CFR 67.107(a)(4)(ii), 67.207(a)(4)(ii), and 67.307(a)(4)(ii), who are medically certified by the FAA subsequent to such diagnosis, are followed under guidelines for special issuance of medical certificates for the period that they hold such certificates.

Therefore, the National Transportation Safety Board recommends that the Federal Aviation Administration:

Ensure that any airman undergoing aeromedical evaluation following a traffic conviction or administrative action that is required to be reported in the FAA Application for Airman Medical Certificate, form 8500-8, item 18v, is required to provide a complete copy of the relevant arrest report and/or court records, and those records are placed in the airman's FAA medical file prior to clinical evaluation for certification. (A-07-41)

Provide a copy of an airman's complete medical record (including relevant arrest and court records) on file in the Aerospace Medical Certification Division to any individual performing a clinical evaluation of that airman related to the airman's application for a medical certificate for the purpose of establishing, ruling out, or monitoring a history or diagnosis of substance dependence (including dependence on alcohol), as defined in 14 *Code of Federal Regulations* 67.107(a)(4)(ii), 67.207(a)(4)(ii), and 67.307(a)(4)(ii), prior to the completion of such an evaluation. (A-07-42)

Require that all airmen clinically diagnosed with substance dependence (including dependence on alcohol), as defined in 14 *Code of Federal Regulations* 67.107(a)(4)(ii), 67.207(a)(4)(ii), and 67.307(a)(4)(ii), who are medically certified by the FAA subsequent to such diagnosis, are followed under guidelines for special issuance of medical certificates for the period that they hold such certificates. (A-07-43)

Please refer to safety recommendations A-07-41 through A-07-43 in your reply. If you need additional information, you may call (202) 314-6177.

Chairman ROSENKER, Vice Chairman SUMWALT, and Members HERSMAN, HIGGINS, and CHEALANDER concurred in these recommendations.

[Original Signed]

By: Mark V. Rosenker
Chairman



National Transportation Safety Board
Washington, D.C. 20594

Safety Recommendation

Date: January 13, 2000

In reply refer to: I-00-1 through -4

Honorable Rodney E. Slater
Secretary
U.S. Department of Transportation
Washington, D.C. 20590

The National Transportation Safety Board has investigated many accidents in all passenger transportation modes in which the use of a licit medication by a vehicle operator has been causal or contributory. As a result, the Safety Board has previously recommended that various agencies take certain actions to address issues pertaining to the use of medications.

In this letter, the Safety Board makes recommendations to the U.S. Department of Transportation (DOT), the modal administrations, and the U.S. Food and Drug Administration (FDA). The Safety Board is recommending that the DOT establish a list of approved medications and/or classes of medications that may be used safely when operating a vehicle, and expressly prohibit the use of any medication not on that list except in certain situations. The Board is also recommending that the DOT evaluate the applicability of similar restrictions for transportation employees in all safety-sensitive positions. The Board is recommending that the modal administrations (the Federal Aviation Administration, the Federal Motor Carrier Safety Administration, the Federal Railroad Administration, the Federal Transit Administration, and the U.S. Coast Guard) establish procedures by which modal vehicle operators who medically require substances not on the DOT's list of approved medications may be allowed, when appropriate, to use those medications while operating a vehicle. The Board is also recommending that the modal administrations educate vehicle operators about the potential for medications to adversely affect their ability to safely operate vehicles, and that the modal administrations that regulate vehicle operators in surface modes work with the DOT to obtain more comprehensive data on the nature and extent of medication involvement in fatal surface mode accidents. Finally, the Safety Board is recommending that the FDA establish and require the use of a clear warning label for medications that may interfere with an individual's ability to operate a vehicle.

This letter summarizes the Safety Board's rationale for issuing the new recommendations.

Accident Experience

On the Pennsylvania Turnpike, at about 4:00 a.m. local time on June 20, 1998, an intercity bus on a scheduled route from New York to Pittsburgh departed the right side of the roadway and struck the back of a parked tractor semitrailer. The busdriver and six passengers were killed. The remaining 16 bus passengers and 2 passengers in the tractor semitrailer were injured. Toxicology testing revealed 0.073 mcg/ml diphenhydramine in the blood of the busdriver. The Safety Board's investigation determined that the accident was caused, in part, by use of this medication.¹ Diphenhydramine is an over-the-counter antihistamine (commonly known by the trade name "Benadryl") with negative effects on alertness, performance, and judgment. It has been demonstrated to impair driving performance in on-the-road and simulator studies.² The Federal Motor Carrier Safety Administration (FMCSA)³ does not specifically prohibit commercial drivers from using over-the-counter antihistamines while driving, and the Federal Transit Administration (FTA) does not regulate the use of any prescription or over-the-counter medications by transit vehicle operators.

On February 4, 1995, at 4:45 p.m. local time, a Cessna 150, N6464T, was destroyed following a loss of control while maneuvering near Arnaudville, Louisiana. The private-rated pilot was fatally injured, and the passenger received minor injuries. Visual meteorological conditions prevailed for the personal flight. The passenger stated they flew over his friend's house: during the second circle he heard a "beeping" and the airplane started "dropping quick." A witness stated that the airplane was circling in a "left bank." The witness also stated, "I heard the engine rev; it looked as though the plane was trying to pull up, but it crashed into the tree and glided into the water and sank very quickly." Tests of the pilot's blood revealed 0.289 mcg/ml diazepam (commonly known by the trade name "Valium," a prescription tranquilizer and muscle relaxant) and 0.364 mcg/ml nordiazepam (an active metabolite of diazepam). Diazepam has been known for many years to impair the performance of complex tasks and mental functions.⁴ The Safety Board's investigation determined that a factor in this accident was "the pilot's use of a drug

¹ National Transportation Safety Board. 2000. *Grayhound Run-off-the-Road Accident, Burnt Cabins, Pennsylvania*, June 20, 1998. Highway Accident Report NTSB/HAR-00/01. Washington, DC.

² Described, for example, in the following references: (a) Gengo, F., Gabos, C., and Miller, J.K. 1989. "The Pharmacodynamics of Diphenhydramine-Induced Drowsiness and Changes in Mental Performance." *Clinical Pharmacology and Therapeutics* 45(1): 15-21. [January]. (b) Gengo, F., Gabos, C., and Mechtler, L. 1990. "Quantitative Effects of Cetirizine and Diphenhydramine on Mental Performance Measured Using an Automobile Driving Simulator." *Annals of Allergy* 64(6): 520-526. [June]. (c) O'Hanlon, J.F., and Ramaekers, J.G. 1995. "Antihistamine Effects on Actual Driving Performance in a Standard Test: A Summary of Dutch Experience, 1989-94." *Allergy*. 50(3): 234-242. [March].

³ A separate agency established within the DOT in December 1999 to regulate and enforce truck and bus safety. The FMCSA assumed the responsibilities of the Office of Motor Carriers that had been part of the Federal Highway Administration within the DOT.

⁴ Described, for example, in the following references: (a) Kleinknecht, R.A., and Donaldson, D. 1975. "A Review of the Effects of Diazepam on Cognitive and Psychomotor Performance." *Journal of Nervous and Mental Disease* 161(6): 399-414. [December]. (b) Smiley, A. 1987. "Effects of Minor Tranquilizers and Antidepressants on Psychomotor Performance." *Journal of Clinical Psychiatry* 48(Suppl.): 22-28. [December]. (c) O'Hanlon, J.F., Vermeiren, A., Uiterwijk, M.M.C., and others. 1995. "Anxiolytics' Effects on the Actual Driving Performance of Patients and Healthy Volunteers in a Standardized Test: An Integration of Three Studies." *Neuropsychobiology* 31(2): 81-88.

that was not approved for use while flying.⁵ The Federal Aviation Administration's (FAA) Civil Aeromedical Institute (CAMI) has published a brochure ("Over the Counter Medications and Flying"⁶) that offers advice regarding the possible effects of certain medications on pilots; however, the FAA does not specifically prohibit pilots from using diazepam while flying.

On December 5, 1996, at 6:32 p.m. local time, a Boeing 767-336, G-BNWM, operated by British Airways, departed Pittsburgh International Airport on an overnight, trans-Atlantic flight to London's Gatwick Airport. About 3 hours into the flight, the first officer became incapacitated with symptoms of light-headedness and nausea. The captain flew the aircraft for the next 4 hours, without the assistance of the first officer, and initially began an approach to the wrong end of the runway in use before an uneventful autoland. The investigation by the Air Accidents Investigation Branch (AAIB) of the United Kingdom revealed that during the flight, the first officer had ingested two tablets of a painkiller containing codeine, a narcotic analgesic with sedative effects.⁷ Although the U.K.'s Civil Aviation Authority has published several advisories on the issue of medications, no agency expressly prohibits the use of this specific medication while flying either in the United States or the United Kingdom.

Since 1987, the Safety Board has investigated over 100 accidents in all modes of passenger transportation that involved prescription or over-the-counter medications whose effects could potentially impair the vehicle's operator. In aviation, the only mode for which comprehensive toxicological testing is routinely performed on nearly all fatally injured operators, the impairment due to these drugs was cited by the Safety Board as a cause or factor in 72 fatal accidents between 1987 and 1995: 18 (1.2 percent) of 1,519 fatal aviation accidents from 1987 through 1989, 20 (1.3 percent) of 1,521 from 1990 through 1992, and 34 (2.5 percent) of 1,376 from 1993 through 1995. These accidents resulted in more than 100 deaths. In 1996 alone, the Safety Board cited impairment due to prescription or over-the-counter medications as a cause or factor in 2.8 percent of all (12 of 424) fatal aviation accidents. These 12 accidents resulted in 20 deaths. By comparison, in 1996, the Safety Board cited impairment due to alcohol as a cause or factor in 1.9 percent of all (8 of 424) fatal aviation accidents. These 8 accidents resulted in 18 deaths. The FAA has noted that the increase in the number of aviation cases with positive test results for drugs may be a reflection of improved methods of toxicological analysis by CAMI rather than any actual increase in drug use.⁸

⁵ (a) NTSB Brief of Accident No. FTW95FA106. (b) Although the Federal Aviation Administration (FAA) has the authority to specifically approve the use of medications that are identified on a pilot's application for an Airman Medical Certificate, the FAA had not done so in this case because the pilot's application did not indicate the use of the medication.

⁶ CAMI Publication AM-400-92/1.

⁷ AAIB Bulletin No. 6/97; Ref: EW/G96/12/1.

⁸ Canfield, D., Flemig, J., Hordinsky, J., and Birky, M. 1995. *Drugs and Alcohol Found in Fatal Civil Aviation Accidents Between 1989 and 1993*. DOT/FAA/AM-95/28. Washington, DC: Federal Aviation Administration. [November].

The Safety Board has issued many safety recommendations since 1979 that address the potential hazards of over-the-counter and prescription medications. The recommendations resulting from the investigations of major accidents and a special study are listed in appendix A. The Board's investigation experience indicates that prescription and over-the-counter medications continue to be factors in transportation accidents and incidents.

Extent of Medication Involvement in Transportation Accidents

The FAA Toxicology and Accident Research Laboratory of CAMI routinely performs comprehensive toxicology testing, including testing for a large number of prescription and over-the-counter medications, on nearly all fatally injured pilots. This laboratory's capability to perform such testing is a result of the FAA's response to the Safety Board's recommendation (A-84-93) that such a capability be established. The FAA publishes summaries of the laboratory's findings about every 5 years. The testing and the reporting are not regulatory requirements.

The Safety Board also utilizes the services of the CAMI Toxicology Laboratory when the Board investigates accidents in the surface modes of transportation. However, the majority of surface transportation accident investigations, which are not conducted by the Safety Board, do not gather information on medications used by vehicle operators other than those drugs identified by DOT regulations in Title 49 *Code of Federal Regulations* (49 CFR) Part 40: marijuana, cocaine, opiates, amphetamines, and phencyclidine (PCP). The Safety Board is aware that the Federal Railroad Administration (FRA) does routinely test for two additional classes of prescription drugs, benzodiazepines and barbiturates, in its investigations, but notes that none of the DOT modal administrations requires testing for drugs beyond those mandated by Part 40. The Safety Board is also aware that the National Highway Traffic Safety Administration (NHTSA) periodically collects and publishes data on the extent of drug involvement in fatally injured noncommercial drivers that includes testing for a substantial number of over-the-counter and prescription medications.⁹

In 1997, the CAMI Toxicology Laboratory detected prescription medications in 14.8 percent (48 of 324) and over-the-counter medications in 21.3 percent (69 of 324) of the fatally injured pilots on whom specimens were received. For comparison, the laboratory detected alcohol (much of it produced postmortem) in only 9.0 percent (29 of 324) of fatally injured pilots in 1997. The Safety Board is aware that, in many cases, the use of prescription or over-the-counter medication was unrelated to the aircraft accident. For investigative purposes, however, the Board has found this comprehensive toxicology information invaluable in evaluating issues of impairment or incapacitation caused by medications or medical conditions.

⁹ See, for example, the following publications: (a) National Highway Traffic Safety Administration. 1977. *A Comparison of Drug Use in Driver Fatalities and Similarly Exposed Drivers*. DOT HS 802 488. Washington, DC. (b) National Highway Traffic Safety Administration. 1992. *The Incidence and Role of Drugs in Fatally Injured Drivers*. DOT HS 808 065. Washington, DC.

In December 1989, the Safety Board asked the DOT to adopt uniform regulations in post-accident and postincident testing of DOT employees in safety-sensitive positions (Safety Recommendation I-89-9). The Board's recommendation also asked that the testing requirements go beyond the five drugs/classes specified in Department of Health and Human Services (DHHS) guidelines and noted specifically that "provisions should be made to test for illicit and licit drugs as information becomes available during an accident investigation." The DOT responded that approved protocols for testing did not exist beyond the five drugs/classes already required. The Safety Board classified the recommendation "Closed—Unacceptable Action" in October 1995. In 1990, in conjunction with its safety study on fatal-to-the-driver heavy truck crashes,¹⁰ the Safety Board recommended that the DOT establish "a postaccident alcohol and other drug analytic test plan for tests to be conducted on a wide range of impairing drugs with results reported at state-of-the-art sensitivity levels" (H-90-14). The DOT responded in September 1990 that it needed time to assess methodology and procedural measures and that the Department was expecting a "resourcing of ideas materials from all government agencies." The recommendation is currently classified "Open—Acceptable Response."

Few data are currently collected regarding the role of prescription and over-the-counter medications in transportation accidents other than in aviation; consequently, there is insufficient information available regarding the extent of involvement of prescription and over-the-counter medications in surface transportation accidents. The Safety Board therefore believes that the DOT, in coordination with the FMCSA, the FRA, the FTA, and the U.S. Coast Guard, should establish comprehensive toxicological testing requirements for an appropriate sample of fatal highway, railroad, transit, and marine accidents to ensure the identification of the role played by common prescription and over-the-counter medications. Further, the DOT and these agencies should review and analyze the results of such testing at intervals not to exceed every 5 years.

Impairment by Over-the-Counter and Prescription Medications

Many prescription and over-the-counter medications have potentially adverse effects on transportation vehicle operators. Common prescription medications whose use has been associated with impaired driving-related skills or actual driving performance include pain relievers,¹¹ anti-anxiety medications,¹² and anti-depressants.¹³ For several of these medications,

¹⁰ National Transportation Safety Board. 1990. *Fatigue, Alcohol, Other Drugs, and Medical Factors in Fatal-to-the-Driver Heavy Truck Crashes*. Safety Study NTSB/SS-90/01 and NTSB/SS-90/02. Washington, DC. 2 Vols.

¹¹ Described, for example, in the following references: (a) Leveille, S.G., Buchner, D.M., Koepsell, T.D., and others. 1994. "Psychoactive Medications and Injurious Motor Vehicle Collisions Involving Older Drivers." *Epidemiology* 5(6): 591-598. [November]. (b) Korttila, K., and Linnoila, M. 1975. "Psychomotor Skills Related to Driving After Intramuscular Administration of Diazepam and Meperidine." *Anesthesiology* 42(6): 685-691. [June]. (c) MacDonald, F.C., Gough, K.J., Nicoll, R.A., and Dow, R.J. 1989. "Psychomotor Effects of Ketorolac in Comparison With Buprenorphine and Diclofenac." *British Journal of Clinical Pharmacology* 27(4):453-459. [April].

¹² Described, for example, in the following references: (a) O'Hanlon, J.F., and Volkerts, E.R. 1986. "Hypnotics and Actual Driving Performance." *Acta Psychiatrica Scandinavica Supplementum* 332: 95-104. (b) Hemmelgarn, B., Suissa, S., Huang, A., and others. 1997. "Benzodiazepine Use and the Risk of Motor Vehicle Crash in the Elderly." *Journal of the American Medical Association* 278(1): 27-31. [July]. (c) Korttila, K., and Linnoila, M.

the subjective effects do not always correlate with impairment;¹⁴ as is the case with alcohol, an individual may be impaired without being aware of the impairment.

Antihistamines are perhaps the most well-known of the over-the-counter medications with potentially impairing effects. A survey conducted in 1994 by an independent research firm found that over 60 percent of allergy sufferers had taken nonprescription antihistamines for allergies.¹⁵ Over one-third of the individuals surveyed stated they did not know the difference between sedating antihistamines (which are available over-the-counter and typically cause performance impairment) and nonsedating antihistamines (which are available only by prescription and typically do not impair performance). Most of those who were surveyed who believed that they had taken a nonsedating antihistamine actually named some other medication. Numerous studies referenced in the medical literature have documented performance-impairing effects for all of the nonprescription antihistamines that are used in the treatment of allergies, often when the individual experiencing the effects is not aware of any impairment. Some of these studies are identified in appendix B.

In 1994, a study reviewed information provided in a national survey on the use of benzodiazepines, a class of tranquilizers including diazepam (also commonly known by the trade name "Valium").¹⁶ This study indicated that for nearly half the purchases of such medications, the patient perceived that the medications were used for a reason that did not correspond to any use supported by the medical literature. Thus, individuals can take impairing medications even

1975. "Psychomotor Skills Related to Driving After Intramuscular Administration of Diazepam And Meperidine." *Anesthesiology* 42(6): 685-91. [June].

¹³ Described, for example, in the following references: (a) Robbe, H.W., and O'Hanlon, J.F. 1995. "Acute and Subchronic Effects of Paroxetine 20 and 40 mg on Actual Driving, Psychomotor Performance and Subjective Assessments in Healthy Volunteers." *European Neuropsychopharmacology* 5(1): 35-42. [March]. (b) Hu, P.S., Trumble, D.A., Foley, D.J., and others. 1998. "Crash Risks of Older Drivers: A Panel Data Analysis." *Accident Analysis and Prevention* 30(5): 569-81. [September]. (c) O'Hanlon, J.F., Robbe, H.W., Vermeeren, A., and others. 1998. "Venlafaxine's Effects on Healthy Volunteers' Driving, Psychomotor, and Vigilance Performance During 15-Day Fixed and Incremental Dosing Regimens." *Journal of Clinical Psychopharmacology* 18(3): 212-21 [June]. (d) Ray, W.A., Fought, R.L., and Decker, M.D. 1992. "Psychoactive Drugs and the Risk of Injurious Motor Vehicle Crashes in Elderly Drivers." *American Journal of Epidemiology* 136(7): 873-883.

¹⁴ Described, for example, in the following references: (a) Mattila, M. 1988. "Acute and Subacute Effects of Diazepam on Human Performance: Comparison of Plain Tablet and Controlled Release Capsule." *Pharmacology and Toxicology* 63(5): 369-74. [November]. (b) Roache, J.D., and Griffiths, R.R. 1985. "Comparison of Triazolam and Pentobarbital: Performance Impairment, Subjective Effects and Abuse Liability." *Journal of Pharmacology and Experimental Therapeutics* 234(1): 120-33. [July]. (c) Aranko, K., Mattila, M.J., and Bordinon, D. 1985. "Psychomotor Effects of Alprazolam and Diazepam During Acute and Subacute Treatment, and During the Follow-Up Phase." *Acta Pharmacologica et Toxicologica* 56(5): 364-72. [May].

¹⁵ Roper Starch Worldwide. 1994. *Seasonal Nasal Allergies: Their Impact on Work and Leisure*. Survey report prepared for Schering/Key (Schering-Plough Pharmaceuticals, Madison, NJ). [July].

¹⁶ Olsson, M., and Pincus, H.A. 1994. "Use of Benzodiazepines in the Community." *Archives of Internal Medicine* 154(11): 1235-40. [June].

when such medications may not be appropriate. Most potentially impairing prescription or over-the-counter medications have significant cognitive effects.¹⁷ The Safety Board is concerned that vehicle operators using such medications might not always be in a position to accurately judge the extent and effect of such impairment: a vehicle operator whose judgment is adversely affected by a medication may decide, inappropriately, that he or she is not impaired.

The Safety Board has previously issued recommendations to address operator awareness of the potential risks of prescription or over-the-counter medications. In 1991, as a result of its investigation of a runway collision in Los Angeles,¹⁸ the Safety Board recommended that the FAA establish a comprehensive educational program to alert pilots to the potential adverse effects on flightcrew performance that may arise from the misuse of prescribed and over-the-counter medication (Safety Recommendation A-91-119). This recommendation was classified "Closed—Acceptable Action" in December 1992 after the FAA issued an informational brochure for Aviation Medical Examiners to distribute to pilots and indicated that training on these issues was being presented at all Aviation Medical Examiner seminars. In 1993, as a result of its investigation of a train derailment in Palatka, Florida,¹⁹ the Safety Board recommended that the National Railroad Passenger Corporation (Amtrak) develop and implement an educational program for employees that describes and illustrates potential consequences of medication use to enable employees to make an informed decision about the relationship between their use of prescribed and over-the-counter medications and their fitness for duty (R-93-17). The Board classified this recommendation "Closed—Acceptable Alternate Action" in May 1995 after Amtrak developed a comprehensive program including training, an information guide, and a wallet card to advise locomotive engineers of the importance of confirming with either their physician or Amtrak's medical director their operating ability while using medications. In 1994, as a result of its investigation of a train derailment in Mobile, Alabama,²⁰ the Safety Board recommended that the DOT require the modal operating administration to develop and disseminate bulletins, notices, circulars, and other documents that call attention to the need for an employee reporting procedure concerning use of medication (over-the-counter and prescription) while on duty and that the DOT urge the transportation industry to develop and implement informational and educational programs related to this subject (I-94-5). The Safety Board classified this recommendation "Closed—Acceptable Action" in August 1995 after the DOT developed and distributed the

¹⁷ Described, for example, in the following references: (a) Hennessy, M.J., Kirkby, K.C., and Montgomery, I.M. 1991. "Comparison of the Amnesic Effects of Midazolam and Diazepam." *Psychopharmacology* 103(4): 545-50. (b) Lader, M. 1988. "Long-Term Treatment of Anxiety: Benefits and Drawbacks." *Psychopharmacology Series* 5: 169-79. (c) Sands, L., Katz, I.R., DiFilippo, S., and others. 1997. "Identification of Drug-Related Cognitive Impairment in Older Individuals. Challenge Studies With Diphenhydramine." *American Journal of Geriatric Psychiatry* 5(2): 156-66. [Spring]. (d) Saarialho Kere, U., Mattila, M.J., Seppälä, T. 1989. "Psychomotor, Respiratory and Neuroendocrinological Effects of a Mu-Opioid Receptor Agonist (Oxycodone) in Healthy Volunteers." *Pharmacology and Toxicology* 65(4): 252-7. [October].

¹⁸ National Transportation Safety Board. 1991. *Runway Collision of USAir Flight 1493, Boeing 737, and Skywest Flight 5569, Fairchild Metroliner, Los Angeles, California, February 1, 1991*. Aircraft Accident Report NTSB/AAR-91/08. Washington, DC.

¹⁹ National Transportation Safety Board. 1993. *Palatka, Florida—December 17, 1991*. Railroad Accident Report NTSB/RAR-93/03/SUM. Washington, DC.

²⁰ National Transportation Safety Board. 1994. *Derailment of Amtrak Train No. 2 on the CSXT Big Bayou Canal Bridge Near Mobile, Alabama, September 22, 1993*. Railroad Accident Report NTSB/RAR-94/01. Washington, DC.

following statement to be used by all operating administrations: "The DOT reminds all DOT industries of the potential threat to public safety caused by the on-duty use of some over-the-counter and prescription medications by persons performing safety-sensitive duties. As a result, we strongly urge all transportation industry employers to include in their employee training materials appropriate information to address this issue."

The Safety Board recognizes the efforts taken by the DOT and the modal administrations in attempting to make information available to vehicle operators regarding the risks of legal medications while on duty. The Board is concerned, however, that current educational initiatives, which in many cases do not educate operators directly, may be inadequate to reach all vehicle operators. In addition, the wide variability in educational methods and programs may not permit all vehicle operators equal access to available information on medication risks. The Board recognizes the difficulty in developing a single source of information that would be applicable to all modes of transportation; therefore, the Safety Board believes that each modal administration within the DOT should develop, then periodically publish, an easy-to-understand source of information for vehicle operators on the hazards of using specific medications when operating a transportation vehicle. Further, each modal administration should establish and implement an educational program targeting vehicle operators that, at a minimum, ensures that all operators are aware of the developed source of information regarding the hazards of using specific medications during vehicle operation. The program developed by Amtrak in response to Safety Recommendation R-93-17 might serve as an example.

Labeling of Medications

Guidance from prescription drug manufacturers for pharmacists and physicians is provided in extensive inserts (normally thousands of words long, in technical language) in medication containers. Information provided to the consumer on prescription medications usually comes from the doctor or pharmacist, along with information on dosage, time intervals, and whether the medication is to be taken with meals. Frequently, the pharmacist affixes a label to the container that provides brief information regarding the effects on an individual's performance; for example, "This drug may impair the ability to drive or operate machinery; USE CARE until you become familiar with its effects" or "May cause DROWSINESS; ALCOHOL may intensify this effect; USE CARE when operating a car or dangerous machinery." The lettering on such labels is usually no larger than 1/16 inch. The FDA, the Federal agency responsible for assuring the safety and effectiveness of medications, typically does not require this labeling for the consumer.

The most conspicuous information presented on the packaging of over-the-counter medications is generally the product name and advertised uses and advantages of the product. Medical guidance for consumers of these medications is often limited to information printed in small lettering on the package. The information typically describes how the medication is to be used, dosage, and time intervals. When applicable, advisories regarding effects on an individual's performance are included, normally phrased as, or similar to, "Use caution when driving a vehicle or operating machinery." Specific wording is often required by FDA regulations for certain medications.

Aug-09-07 10:34am From-NTSB

202-314-6110

T-599 P.037/039 F-808

**National Transportation Safety Board**

Washington, D.C. 20594

JUN 12 2007

Office of the Chairman

Docket Management Facility
U.S. Department of Transportation
400 Seventh Street, SW
Nassif Building
Room PL-401
Washington, DC 20590-0001

Attention: Docket Number FAA 2007-27812; Notice No. 07-08

Dear Sir or Madam:

The National Transportation Safety Board has reviewed the Federal Aviation Administration (FAA) Notice of Proposed Rulemaking (NPRM), *Modification of Certain Medical Standards and Procedures and Duration of Certain Medical Certificates; Proposed Rule*, which was published at 72 *Federal Register* 18092 on April 10, 2007. The NPRM proposes to extend the duration of first- and third-class medical certificates for certain individuals. The intent is to improve the efficiency of the medical certification program and service provided to medical certificate applicants. The NPRM proposes that, for airmen under 40 years of age, the duration be increased from 3 years to 5 years for third-class medical certificates, and from 6 months to 1 year for first-class medical certificates. The FAA projects substantial cost savings and minimal risk.

The Safety Board agrees that the risk of impairing or incapacitating medical conditions causing an aircraft accident is low, compared to other accident causes. This is likely due, at least in part, to the existing comprehensive system for the medical evaluation of pilots. The Safety Board is concerned that the changes in the proposed rule will increase the time between the discovery of a new medical condition and the required reporting of that condition on a pilot's application for a medical certificate. In addition, National Driver Registry (NDR) inquiries, currently performed in conjunction with pilot applications for medical certificates, may be considerably less effective at detecting possible evidence of substance abuse and dependence disorders if the interval between such inquiries is extended.

In conjunction with this rulemaking, the FAA performed a limited review of 100 randomly sampled records from pilots under 40 years of age. The review revealed that 2 percent had significant pathology that developed since being examined for their medical certifications.



... a person who holds a current medical certificate issued under part 67 of this chapter shall not act as pilot in command, or in any other capacity as a required pilot flight crewmember, while that person: ...

(2) Is taking medication or receiving other treatment for a medical condition that results in the person being unable to meet the requirements for the medical certificate necessary for the pilot operation.

The only mention of specific medications in Part 67, which governs medical standards and certification, is insulin or hypoglycemic drugs for the control of diabetes. The regulations in Sections 67.113, 67.213, and 67.313 state that the standards for any class of medical certificate are

(c) No medication or other treatment that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgement relating to the medication or other treatment involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

The Federal Air Surgeon does not, however, publish a list of either acceptable or unacceptable medications for airman duties.

Part 91, which governs general operating and flight rules, indicates in Section 91.17 that

No person may act or attempt to act as a crewmember of a civil aircraft ... (3) While using any drug that affects the person's faculties in any way contrary to safety. ...

The regulation does not specify who makes the determination as to whether the drug affects the pilot's faculties in any way contrary to safety. In 1985, the Safety Board commented on the regulation (then in Section 91.11) in a letter to the FAA regarding Safety Recommendation A-84-94, stating that "in essence, the FAA is requiring the pilot himself to determine whether a substance will degrade his own performance without providing any guidance to make this judgment."

In 1962, the FAA published its "Guide to Drug Hazards in Aviation Medicine" (Advisory Circular 91.11-1) for the use of Aviation Medical Examiners, with specific indications for each drug or drug class reviewed as to whether airman duties were or were not contraindicated. The publication was reprinted in 1979, but the Safety Board notes that it has not been updated or reprinted since that time.

Federal regulations regarding the use of prescription and over-the-counter medications on the highways (49 CFR 382.213) apply to commercial drivers:

- (a) No driver shall report for duty or remain on duty requiring the performance of safety sensitive functions when the driver uses any controlled substance, except when the use is pursuant to the instructions of a licensed medical practitioner, as defined in Sec. 382.107 of this part, who has advised the driver that the substance will not adversely affect the driver's ability to safely operate a commercial motor vehicle.
- (b) No employer having actual knowledge that a driver has used a controlled substance shall permit the driver to perform or continue to perform a safety-sensitive function.
- (c) An employer may require a driver to inform the employer of any therapeutic drug use.

The above restrictions do not apply to most over-the-counter medications, and the regulation does not require that a driver document any instructions received from a medical practitioner.

The Federal regulations covering the use of prescription and over-the-counter medications by marine operators are contained in 33 CFR Part 95:

Sec. 95.045 General operating rules for vessels inspected, or subject to inspection, under Chapter 33 of Title 46 United States Code.

While on board a vessel inspected, or subject to inspection, under Chapter 33 of Title 46 United States Code, a crewmember (including a licensed individual), pilot, or watchstander not a regular member of the crew:

- (a) Shall not perform or attempt to perform any scheduled duties within four hours of consuming any alcohol;
- (b) Shall not be intoxicated at any time;
- (c) Shall not consume any intoxicant while on watch or duty; and
- (d) May consume a legal non-prescription or prescription drug provided the drug does not cause the individual to be intoxicated.

Sec. 95.050 Responsibility for compliance.

- (a) The marine employer shall exercise due diligence to assure compliance with the applicable provisions of this part.
- (b) If the marine employer has reason to believe that an individual is intoxicated, the marine employer shall not allow that individual to stand watch or perform other duties.

The regulations further define an intoxicant as "any form of alcohol, drug or combination thereof," and provide the following guidance with regard to intoxication with any substance other than alcohol:

Sec. 95.020 Standard of intoxication.

An individual is intoxicated when: . . .

- (c) The individual is operating any vessel and the effect of the intoxicant(s) consumed by the individual on the person's manner, disposition, speech, muscular movement, general appearance or behavior is apparent by observation.

The regulations do not specify any objective method by which intoxication because of prescription or over-the-counter medications can be recognized or prevented.

The FTA regulations do not address the use of prescription or over-the-counter medications by transit vehicle operators.

The FRA has perhaps the most explicit requirements regarding medication use by transportation operators, defined in 49 CFR Part 219:

Sec. 219.101 Alcohol and drug use prohibited.

(b) Controlled substance. "Controlled substance" is defined by Sec. 219.5 of this part. Controlled substances are grouped as follows: Marijuana, narcotics (such as heroin and codeine), stimulants (such as cocaine and amphetamines), depressants (such as barbiturates and minor tranquilizers), and hallucinogens (such as the drugs known as PCP and LSD). Controlled substances include illicit drugs (Schedule I), drugs that are required to be distributed only by a medical practitioner's prescription or other authorization (Schedules II through IV, and some drugs on Schedule V), and certain preparations for which distribution is through documented over the counter sales (Schedule V only).

Sec. 219.102 Prohibition on abuse of controlled substances.

On and after October 2, 1989, no employee who performs covered service may use a controlled substance at any time, whether on duty or off duty, except as permitted by Sec. 219.103 of this subpart.

Sec. 219.103 Prescribed and over-the-counter drugs.

(a) This subpart does not prohibit the use of a controlled substance (on Schedule II through V of the controlled substance list) prescribed or authorized by a medical practitioner, or possession incident to such use, if

- (1) The treating medical practitioner or a physician designated by the railroad has made a good faith judgment, with notice of the employee's assigned duties and on the basis of the available medical history, that use of the substance by the employee at the prescribed or authorized dosage level is consistent with the safe performance of the employee's duties;
- (2) The substance is used at the dosage prescribed or authorized; and

(3) In the event the employee is being treated by more than one medical practitioner, at least one treating medical practitioner has been informed of all medications authorized or prescribed and has determined that use of the medications is consistent with the safe performance of the employee's duties (and the employee has observed any restrictions imposed with respect to use of the medications in combination).

(b) This subpart does not restrict any discretion available to the railroad to require that employees notify the railroad of therapeutic drug use or obtain prior approval for such use.

The above restrictions clearly require consultation with a medical practitioner. However, most over-the-counter medications are not covered by the regulation,²² and no requirement is noted for documentation of medical consultation.

The Safety Board recognizes the intent of each modal administration to prohibit the use of medications that could adversely affect the ability of an individual to safely control a vehicle. The Board is concerned, however, that the regulations currently in place may not provide sufficient guidance to operators to effectively achieve this aim. Further, the Board notes that enforcement of the current regulations may be difficult, particularly for those administrations that lack a medical staff tasked to make subjective evaluations as to potential impairment or to evaluate documentation that no such impairment exists with a particular medication. The Safety Board therefore believes that the DOT should develop, with assistance from experts on the effects of pharmacological agents on human performance and alertness, a list of approved medications and/or classes of medications that may be used safely while operating a vehicle.

The Safety Board recognizes that some vehicle operators may occasionally need to use a medication that would not be on the DOT's list of approved medications. Measures are thus needed for operators in all modes to ensure that they are not under the influence of impairing medications while operating a vehicle. The FAA, in its brochure entitled "Over the Counter Medications and Flying," provides pilots the following rule of thumb: "If the label warns of side-effects, do not fly until twice the recommended dosing interval has passed." It seems prudent to restrict operators in all modes from using any medication not on the DOT's list of approved medications for twice the recommended dosing interval prior to vehicle operation. The Board also recognizes, however, that there will be circumstances in which use of some medications not on the DOT list might not adversely impair an operator's ability to safely operate a vehicle. Because precise physical requirements for vehicle operation may differ substantially from mode to mode, the applicable modal administrations, with assistance from experts, are the appropriate agents to determine and identify the circumstances in which an individual may safely operate a vehicle while using a medication not on the DOT list. Thus, the Safety Board believes that the DOT should expressly prohibit the use of any medication not on the DOT's list of approved medications for twice the recommended dosing interval before or during vehicle operation, except as specifically allowed, when appropriate, by procedures or criteria established by the applicable modal administration (the Federal Aviation Administration, the Federal Motor Carrier Safety Administration, the Federal Railroad Administration, the Federal Transit Administration, or the

²² There are substances that may be purchased without a prescription for which over-the-counter sales must be documented. Even though these substances are available over the counter, they are considered controlled medications. (Certain codein-containing cough syrups fall into this category.)

U.S. Coast Guard). In conjunction with this recommendation, the Safety Board is asking the FAA, FMCSA, FRA, FTA, and the Coast Guard to establish, with assistance from experts on the effects of pharmacological agents on human performance and alertness, procedures or criteria by which modal vehicle operators who medically require substances not on the DOT's list of approved medications may be allowed, when appropriate, to use those medications while operating a vehicle.

The Safety Board notes that the operators of transportation vehicles are not the only individuals performing safety-sensitive functions in the transportation industry. Supervisors, maintenance personnel, controllers, dispatchers, and others make critical contributions to the overall safety of the traveling public. Because of their important roles in transportation safety, these employees are covered by DOT regulations in 49 CFR Part 40 regarding workplace drug testing. The Board has concerns regarding the use by these individuals of licit medications that may impair their performance; however, the Board is not aware of any data that identify medication use by these individuals as a cause of or factor in specific accidents. The Safety Board therefore believes that the DOT should evaluate the applicability of the restrictions recommended above (for vehicle operators) to transportation employees in all safety-sensitive positions. If appropriate, the DOT should implement such restrictions within 2 years of their implementation for vehicle operators.

Therefore, the National Transportation Safety Board recommends that the U.S. Department of Transportation:

Establish, in coordination with the Federal Motor Carrier Safety Administration, the Federal Railroad Administration, the Federal Transit Administration, and the U.S. Coast Guard, comprehensive toxicological testing requirements for an appropriate sample of fatal highway, railroad, transit, and marine accidents to ensure the identification of the role played by common prescription and over-the-counter medications. Review and analyze the results of such testing at intervals not to exceed every 5 years. (I-00-1)

Develop, with assistance from experts on the effects of pharmacological agents on human performance and alertness, a list of approved medications and/or classes of medications that may be used safely when operating a vehicle. (I-00-2)

Expressly prohibit the use of any medication not on the U.S. Department of Transportation's list of approved medications (described in Safety Recommendation I-00-2) for twice the recommended dosing interval before or during vehicle operation, except as specifically allowed, when appropriate, by procedures or criteria established by the applicable modal administration (the Federal Aviation Administration, the Federal Motor Carrier Safety Administration, the Federal Railroad Administration, the Federal Transit Administration, or the U.S. Coast Guard). (I-00-3)

Evaluate the applicability of the restrictions (for vehicle operators) described in Safety Recommendations I-00-2 and -3 to transportation employees in all safety-sensitive positions. If appropriate, implement such restrictions within 2 years of their implementation for vehicle operators. (I-00-4)

Also, the Safety Board issued safety recommendations to the Federal Aviation Administration, the U.S. Coast Guard, the Federal Motor Carrier Safety Administration, the Federal Railroad Administration, the Federal Transit Administration, and the U.S. Food and Drug Administration. The recommendations, as issued to each of these agencies, as well as the recommendations to the DOT, are presented in appendix C.

Chairman HALL and Members HAMMERSCHMIDT, GOGLIA, and BLACK concurred in these recommendations.

Original Signed

By: Jim Hall
Chairman

Appendix A
Status of Previous Recommendations
Pertaining to the Use of or Testing for
Prescription or Over-the-Counter Medications

Safety Recommendation No.: M-79-25
Date Issued: March 2, 1979
Recipient: U.S. Coast Guard
Status: Closed—Reconsidered (6/21/82)
Recommendation:

Establish standards for the taking of medication by watchstanders on Coast Guard vessels to insure that the medication does not impede the individual's ability to perform his duties.

Safety Recommendation No.: A-84-93
Date Issued: August 15, 1984
Recipient: FAA
Status: Closed—Acceptable Action (8/29/90)
Recommendation:

Establish at the Civil Aeromedical Institute the capability to perform state-of-the-art toxicological tests on the blood, urine, and tissue of pilots involved in fatal accidents to determine the levels of both licit and illicit drugs at both therapeutic and abnormal levels.

Safety Recommendation No.: A-84-94
Date Issued: August 15, 1984
Recipient: Federal Aviation Administration
Status: Closed—Unacceptable Action (1/13/86)
Recommendation:

Review the research and literature on the potential effects on pilot performance of both licit and illicit drugs, in both therapeutic and abnormal levels, and use that to develop and actively disseminate to pilots usable guidelines on potential drug interactions with piloting ability.

Safety Recommendation No.: A-84-96
Date Issued: August 15, 1984
Recipient: U.S. Department of Transportation
Status: Closed—Reconsidered (4/28/95)

Recommendation:

Review the existing research and literature in this area and institute research to: (1) determine the potential effects of both licit and illicit drugs, especially marijuana, in both therapeutic and abnormal levels, on human performance; (2) obtain correlations between toxicological findings of drug levels in blood, urine, and other specimens and various behavioral measurements; and (3) assess the effects of various drugs on the specific tasks performed by the operator in all transportation modes.

Safety Recommendation No.: M-86-13**Date Issued:** February 27, 1986**Recipient:** Tourship Co., S.A. (owner/operator of the M/V *A. Regina*)**Status:** Closed—No longer applicable (8/11/87)**Recommendation:**

Establish a procedure to require that your vessel masters and watchstanding officers report when they are taking any medication, determine whether such medication may affect the performance of their duties, and arrange for a qualified relief if necessary.

Safety Recommendation No.: M-86-15**Date Issued:** February 27, 1986**Recipient:** U.S. Coast Guard**Status:** Closed—Acceptable Alternate Action (8/20/93)**Recommendation:**

Require that masters and watchstanding officers on U.S. passenger vessels carrying 50 or more passengers, including ferries, report to the vessel's operation company when they are taking any medication so that a medical determination can be made as to the effect of such medication on their ability to perform watchkeeping tasks properly.

Safety Recommendation No.: R-86-37**Date Issued:** October 13, 1986**Recipient:** Federal Transit Administration**Status:** Closed—Acceptable Action/Superseded (2/1/88)**Recommendation:**

Require the removal of employees from safety-sensitive positions if the rail rapid transit medical department determines that the employees' use of a prescription drug will affect their work performance.

Safety Recommendation No.: I-89-4
Date Issued: December 5, 1989
Recipient: U.S. Department of Transportation
Status: Closed—Unacceptable Action (5/19/95)
Recommendation:

Develop postaccident and postincident testing regulations that are separate from the pre-employment, random, and reasonable suspicion testing regulations in all modal agencies.

Safety Recommendation No.: I-89-9
Date Issued: December 5, 1989
Recipient: U.S. Department of Transportation
Status: Closed—Unacceptable Action (10/4/95)
Recommendation:

Adopt uniform regulations in postaccident and postincident testing of U.S. Department of Transportation employees in safety sensitive positions. The regulations should provide: testing requirements that include alcohol and drugs beyond the five drugs or classes specified in the Department Of Health and Human Services (DHHS) guidelines and that are not limited to the cutoff thresholds specified in the DHHS guidelines. Provisions should be made to test for illicit and licit drugs as information becomes available during an accident investigation.

Safety Recommendation No.: H-90-14
Date Issued: April 4, 1990
Recipient: U.S. Department of Transportation
Status: Open—Acceptable Response
Recommendation:

Establish, with the Department of Health and Human Services and other organizations as appropriate, a postaccident alcohol and other drug analytic test plan for tests to be conducted on a wide range of impairing drugs with results reported at state-of-the-art sensitivity levels.

Safety Recommendation No.: H-90-15
Date Issued: April 4, 1990
Recipient: U.S. Department of Transportation
Status: Open—Awaiting Response

Recommendation:

Provide funding incentives, guidance and assistance to the States to obtain complete toxicological tests and report results (including drug tests requested) to DOT on all vehicle operators involved in fatal commercial vehicle accidents.

Safety Recommendation No.: H-90-16
Date Issued: April 4, 1990
Recipient: National Highway Traffic Safety Administration
Status: Closed—Acceptable Response (11/24/98)
Recommendation:

Revise the Fatal Accident Reporting System to include standardized drug toxicological tests requested in each fatal accident and results, both single and multiple drug, which would include an estimating system similar to that now used to estimate national alcohol involvement in fatal accidents.

Safety Recommendation No.: H-90-34
Date Issued: April 4, 1990
Recipient: U.S. Department of Health and Human Services
Status: Open—Acceptable Response
Recommendation:

Establish, with the Department of Transportation and other organizations as appropriate, a postaccident alcohol and other drug analytic test plan for tests to be conducted on a wide range of impairing drugs with results reported at state-of-the-art sensitivity levels.

Safety Recommendation No.: A-91-119
Date Issued: December 3, 1991
Recipient: Federal Aviation Administration
Status: Closed—Acceptable Action (12/11/92)
Recommendation:

Establish a comprehensive educational program to alert pilots to the potential adverse effects on flightcrew performance that may arise from the misuse of prescribed and over-the-counter medication.

Safety Recommendation No.: R-93-17
Date Issued: June 5, 1993
Recipient: National Railroad Passenger Corporation (Amtrak)
Status: Closed—Acceptable Alternate Action (3/16/95)

Recommendation:

Develop and implement an educational program for employees that describe and illustrate potential consequences of medication use to enable employees to make an informed decision about the relationship between their use of prescribed and over-the-counter medications and their fitness for duty.

Safety Recommendation No.: I-94-5
Date Issued: September 30, 1994
Recipient: U.S. Department of Transportation
Status: Closed—Acceptable Action (8/17/95)
Recommendation:

Require the modal operating administration to develop and disseminate bulletins, notices, circulars, and other documents that call attention to the need for an employee-reporting procedure concerning use of medication (over-the-counter and prescription) while on duty and that urge the transportation industry to develop and implement informational and educational programs related to this subject.

Safety Recommendation No.: M-94-45
Date Issued: September 30, 1994
Recipient: Warrior and Gulf Navigation Company
Status: Closed—Acceptable Action (1/9/95)
Recommendation:

Establish procedures that encourage towboat operators to inform management when they are taking medication, to determine whether such medication may affect performance of their duties, and to arrange for a qualified relief, if necessary.

Safety Recommendation No.: M-95-22
Date Issued: July 11, 1995
Recipient: All Alaskan Seafood, Inc.
Status: Closed—No Longer Applicable (1/27/98)
Recommendation:

Develop and institute a program designed to require employees to inform management of any medication being taken that could potentially affect performance.

Safety Recommendation No.: M-97-42
Date Issued: June 26, 1997
Recipient: U.S. Coast Guard
Status: Open—Acceptable Response

Recommendation:

Review, in consultation with experts in occupational health, your medical standards, guidelines, and examination forms to ensure that they require the disclosure and appropriate evaluation of the history or presence of any medical conditions, symptoms, or medication use that would affect an individual's fitness to pilot a vessel.

Safety Recommendation No.: M-97-45**Date Issued:** June 26, 1997**Recipient:** The State Pilot Commissions, and the
Alaska Board of Marine Pilots**Status:** Open—Acceptable Response**Recommendation:**

Review, in consultation with experts in occupational health, your medical standards, guidelines, and examination forms to ensure that they require the disclosure and appropriate evaluation of the history or presence of any medical conditions, symptoms, or medication use that would affect an individual's fitness to pilot a vessel.

Appendix B

A Sampling of Studies on Antihistamine Effects

- Betts, T., Markman, D., Debenham, S., and others. 1984. "Effects of Two Antihistamine Drugs on Actual Driving Performance." *British Medical Journal* (Clinical Research Edition) 288(6413): 281-282.
- Brookhuis, K.A., De Vries, G., and De Waard, D. 1993. "Acute and Subchronic Effects of the H1-Histamine Receptor Antagonist Ebastine in 10, 20, and 30 mg Dose, and Tripolidine 10 mg on Car Driving Performance." *British Journal of Clinical Pharmacology* 36(1): 67-70.
- Burns, M., Shanahan, J.E., and Shellenberger, C.H. 1994. "A Laboratory Study of Patients With Chronic Allergic Rhinitis: Antihistamine Effects on Skilled Performance." *Journal of Allergy and Clinical Immunology* 93(4): 716-724.
- Clarke, C.H., and Nicholson, A.N. 1978. "Performance Studies With Antihistamines." *British Journal of Clinical Pharmacology* 6(1): 31-35.
- Gilmore, T.M., Alexander, B.H., Mueller, B.A., and Rivara, F.P. 1996. "Occupational Injuries and Medication Use." *American Journal of Industrial Medicine* 30(2):234-239.
- Hindmarch, I., and Bhatti, J.Z. 1987. "Psychomotor Effects of Astemizole and Chlorpheniramine, Alone and in Combination With Alcohol." *International Clinical Psychopharmacology* 2(2): 117-119.
- Meltzer, E.O. 1990. "Antihistamine- and Decongestant-Induced Performance Decrements." *Journal of Occupational Medicine* 32(4): 327-334.
- Millar, K., and Wilkinson, R.T. 1981. "The Effects Upon Vigilance and Reaction Speed of the Addition of Ephedrine Hydrochloride to Chlorpheniramine Maleate." *European Journal of Clinical Pharmacology* 20(5): 351-357.
- Nicholson, A.N., and Stone, B.M. 1986. "Antihistamines: Impaired Performance and the Tendency To Sleep." *European Journal of Clinical Pharmacology* 30(1): 27-32.
- O'Hanlon, J.F., and Ramaekers, J.G. 1995. "Antihistamine Effects on Actual Driving Performance in a Standard Test: A Summary of Dutch Experience, 1989-94." *Allergy* 50(3): 234-242.
- Rice, V.J., and Snyder, H.L. 1993. "The Effects of Benadryl and Hismanal on Psychomotor Performance and Perceived Performance." *Aviation, Space, and Environmental Medicine* 64(8): 726-734.
- Stammer, G. 1985. "Antihistamines and Highway Safety." *Accident Analysis and Prevention* 17(4): 311-317.

Appendix C
New Safety Recommendations Pertaining to the
Use of Licit Medications, Issued to the DOT, the
Modal Administrations, and the FDA

To the U.S. Department of Transportation:

Establish, in coordination with the Federal Motor Carrier Safety Administration, the Federal Railroad Administration, the Federal Transit Administration, and the U.S. Coast Guard, comprehensive toxicological testing requirements for an appropriate sample of fatal highway, railroad, transit, and marine accidents to ensure the identification of the role played by common prescription and over-the-counter medications. Review and analyze the results of such testing at intervals not to exceed every 5 years. (I-00-1)

Develop, with assistance from experts on the effects of pharmacological agents on human performance and alertness, a list of approved medications and/or classes of medications that may be used safely when operating a vehicle. (I-00-2)

Expressly prohibit the use of any medication not on the U.S. Department of Transportation's list of approved medications (described in Safety Recommendation I-00-2) for twice the recommended dosing interval before or during vehicle operation, except as specifically allowed, when appropriate, by procedures or criteria established by the applicable modal administration (the Federal Aviation Administration, the Federal Motor Carrier Safety Administration, the Federal Railroad Administration, the Federal Transit Administration, or the U.S. Coast Guard). (I-00-3)

Evaluate the applicability of the restrictions (for vehicle operators) described in Safety Recommendations I-00-2 and -3 to transportation employees in all safety-sensitive positions. If appropriate, implement such restrictions within 2 years of their implementation for vehicle operators. (I-00-4)

To the Federal Aviation Administration:

Establish, with assistance from experts on the effects of pharmacological agents on human performance and alertness, procedures or criteria by which pilots who medically require substances not on the U.S. Department of Transportation's list of approved medications may be allowed, when appropriate, to use those medications when flying. (A-00-4)

Develop, then periodically publish, an easy-to-understand source of information for pilots on the hazards of using specific medications when flying. (A-00-5)

Establish and implement an educational program targeting pilots that, at a minimum, ensures that all pilots are aware of the source of information described in Safety Recommendation A-00-5 regarding the hazards of using specific medications when flying. (A-00-6)

To the Federal Motor Carrier Safety Administration:

Establish, with assistance from experts on the effects of pharmacological agents on human performance and alertness, procedures or criteria by which highway vehicle operators who medically require substances not on the U.S. Department of Transportation's list of approved medications may be allowed, when appropriate, to use those medications when driving. (H-00-12)

Develop, then periodically publish, an easy-to-understand source of information for highway vehicle operators on the hazards of using specific medications when driving. (H-00-13)

Establish and implement an educational program targeting highway vehicle operators that, at a minimum, ensures that all operators are aware of the source of information described in Safety Recommendation H-00-13 regarding the hazards of using specific medications when driving. (H-00-14)

Establish, in coordination with the U.S. Department of Transportation, the Federal Railroad Administration, the Federal Transit Administration, and the U.S. Coast Guard, comprehensive toxicological testing requirements for an appropriate sample of fatal highway, railroad, transit, and marine accidents to ensure the identification of the role played by common prescription and over-the-counter medications. Review and analyze the results of such testing at intervals not to exceed every 5 years. (H-00-15)

To the Federal Railroad Administration:

Establish, with assistance from experts on the effects of pharmacological agents on human performance and alertness, procedures or criteria by which train operating crewmembers who medically require substances not on the U.S. Department of Transportation's list of approved medications may be allowed, when appropriate, to use those medications when performing their duties. (R-00-1)

Develop, then periodically publish, an easy-to-understand source of information for train operating crewmembers on the hazards of using specific medications when performing their duties. (R-00-2)

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Establish and implement an educational program targeting train operating crewmembers that, at a minimum, ensures that all crewmembers are aware of the source of information described in Safety Recommendation R-00-2 regarding the hazards of using specific medications when performing their duties. (R-00-3)

Establish, in coordination with the U.S. Department of Transportation, the Federal Motor Carrier Safety Administration, the Federal Transit Administration, and the U.S. Coast Guard, comprehensive toxicological testing requirements for an appropriate sample of fatal highway, railroad, transit, and marine accidents to ensure the identification of the role played by common prescription and over-the-counter medications. Review and analyze the results of such testing at intervals not to exceed every 5 years. (R-00-4)

To the Federal Transit Administration:

Establish, with assistance from experts on the effects of pharmacological agents on human performance and alertness, procedures or criteria by which transit vehicle operators who medically require substances not on the U.S. Department of Transportation's list of approved medications may be allowed, when appropriate, to use those medications when operating transit vehicles. (R-00-5)

Develop, then periodically publish, an easy-to-understand source of information for transit vehicle operators on the hazards of using specific medications when operating transit vehicles. (R-00-6)

Establish and implement an educational program targeting transit vehicle operators that, at a minimum, ensures that all operators are aware of the source of information described in Safety Recommendation R-00-6 regarding the hazards of using specific medications when operating transit vehicles. (R-00-7)

Establish, in coordination with the U.S. Department of Transportation, the Federal Motor Carrier Safety Administration, the Federal Railroad Administration, and the U.S. Coast Guard, comprehensive toxicological testing requirements for an appropriate sample of fatal highway, railroad, transit, and marine accidents to ensure the identification of the role played by common prescription and over-the-counter medications. Review and analyze the results of such testing at intervals not to exceed every 5 years. (R-00-8)

To the United States Coast Guard:

Establish, with assistance from experts on the effects of pharmacological agents on human performance and alertness, procedures or criteria by which vessel operating personnel who medically require substances not on the U.S. Department of Transportation's list of approved medications may be allowed, when appropriate, to use those medications when performing their duties. (M-00-1)

Develop, then periodically publish, an easy-to-understand source of information for vessel operating personnel on the hazards of using specific medications when performing their duties. (M-00-2)

Establish and implement an educational program targeting vessel operating personnel that, at a minimum, ensures that all operating personnel are aware of the source of information described in Safety Recommendation M-00-2 regarding the hazards of using specific medications when performing their duties. (M-00-3)

Establish, in coordination with the U.S. Department of Transportation, the Federal Motor Carrier Safety Administration, the Federal Railroad Administration, and the Federal Transit Administration, comprehensive toxicological testing requirements for an appropriate sample of fatal highway, railroad, transit, and marine accidents to ensure the identification of the role played by common prescription and over-the-counter medications. Review and analyze the results of such testing at intervals not to exceed every 5 years. (M-00-4)

To the Food and Drug Administration:

Establish a clear, consistent, easily recognizable warning label for all prescription and over-the-counter medications that may interfere with an individual's ability to operate a vehicle. Require that the label be prominently displayed on all packaging of such medications. (I-00-5)

Though this limited review did not detect a difference in the number of conditions found between pilots examined at 6- and 12-month intervals, the increased time between examinations would necessarily increase the average time from the onset of a new condition to the pilot's next examination. If the 2 percent of pilots under 40 noted in the FAA's review who developed significant medical conditions between examinations is representative, the proposed rule may delay thousands of pilots from being evaluated for new medical conditions if they are not required to report such conditions until they apply for their next medical certificate.

Existing FAA regulations do not require pilots to report medical conditions between examinations, though they do require pilots to refrain from their duties when they are aware of a potentially disqualifying medical condition. Title 14 *Code of Federal Regulations* 61.53(a) states the following:

[An airman] shall not act as pilot in command, or in any other capacity as a required pilot flight crewmember, while that person: (1) knows or has reason to know of any medical condition that would make the person unable to meet the requirements for the medical certificate necessary for the pilot operation; or (2) is taking medication or receiving other treatment for a medical condition that results in the person being unable to meet the requirements for the medical certificate necessary for the pilot operation.

The FAA notes that ICAO standards related to duration of medical certificate are consistent with the proposed rulemaking, and justifies the proposed rule "in part because of the international application of less restrictive standards that has had no reported adverse impact on safety." However, international standards, unlike current or proposed U.S. regulations, explicitly stipulate that conditions arising between scheduled examinations be reported so that such conditions can be evaluated promptly. ICAO Annex 1 (1.2.6.1.1) recommends that "Licence holders should inform the Licensing Authority of ... any decrease in medical fitness of a duration of more than 20 days or which requires continued treatment with prescribed medication or which has required hospital treatment." The European Joint Aviation Authorities (JAA) regulations require the following:

Holders of medical certificates shall, without undue delay, seek the advice of the AMS [aeromedical section], an AMC [aeromedical centre] or an AME [authorised medical examiner] when becoming aware of: (1) hospital or clinic admission for more than 12 hours; or (2) surgical operation or invasive procedure; or (3) the regular use of medication; or (4) the need for regular use of correcting lenses" (JAR-FCL 3.040).

The Safety Board believes that the proposed rule should follow the ICAO and JAA examples above and require that potentially disqualifying conditions be reported to the FAA in a timely fashion. Such a requirement should not substantially add to the burden on either the pilot or the FAA. Pilots are already required to cease operating as flight crew when such conditions exist, so those who intend to continue operations would need FAA approval to do so. The FAA would necessarily perform a complete evaluation of the condition at the time of the airman's next application for medical certificate, and an evaluation performed at the time that the

condition is initially discovered would be no more time consuming and considerably more timely. The Safety Board encourages the FAA to change the proposed rule accordingly.

The Safety Board is also concerned that an unintended effect of extending the time between examinations might be to increase the interval between NDR inquiries. Such inquiries, currently performed in conjunction with pilot applications for medical certificates, are a significant source of information on substance abuse and dependence disorders that might otherwise go unrecognized or unreported. Many U.S. states limit the information available through the NDR to the most recent 3 years, so if inquiries are performed at longer intervals, it is likely that some relevant convictions will be missed. Substance abuse and dependence are conditions that are *not* associated with aging, and that will often respond well to early intervention; it would therefore be unwise to limit the FAA's ability to discover such conditions in the younger population (under the age of 40), who may stand to benefit most from evaluation and treatment. The Safety Board therefore feels that this NPRM should require policy changes as necessary to ensure an appropriate frequency of NDR database evaluations that is no less than currently performed.

The Safety Board appreciates the opportunity to comment on this NPRM.

Sincerely,

A handwritten signature in black ink, appearing to read 'Mark V. Rosenker', written in a cursive style.

Mark V. Rosenker
Chairman

The labels commonly found on both prescription and nonprescription medications alert consumers that they will need to determine whether they are too impaired to operate a vehicle. Such advisories do not account for the possibility that the medication may impair an individual's ability to make such a determination.

Some countries require clear warnings regarding possible effects of medications on driving. For example, Sweden's Medical Products Agency Code of Statutes 1995:11 (Chapter II, Section 2.6) requires that "medicinal products which can affect ability to react and consequently ability to drive vehicles or perform work which entails risks or requires precision shall be labeled with a warning triangle." The requirements further specify that a red triangle "shall appear in a prominent position" on labels of such medications. Although not required by Australian law, pharmacists in that country often affix a red triangle in a prominent location on labels of prescription medications that may adversely affect driving performance.

Many studies have documented difficulties encountered by consumers, particularly the elderly, with reading and understanding medication labels and instructions.²¹ The current labels (particularly in the case of over-the-counter medications) may not provide sufficient direction for vehicle operators in all circumstances. Further, the advice to "use care" when operating a vehicle is unlikely to restrict such operation by an individual who is unaware of any effects of the medication. The existing labels and inserts used in the United States for prescription and over-the-counter medications that may impair vehicle operation do not always communicate the risk for impairment in a manner that can be easily understood. The Safety Board thus believes that the FDA should establish a clear, consistent, easily recognizable warning label for all prescription and over-the-counter medications that may interfere with an individual's ability to operate a vehicle. The FDA should also require that such a label be prominently displayed on all packaging of such medications.

Regulatory Guidance

There is relatively little regulatory guidance available from the DOT, its modal administrations, the FDA, or other regulatory agency for vehicle operators with regard to use of over-the-counter and prescription medications. Guidance from the FAA in *Federal Aviation Regulations* 14 CFR Parts 61, 67, and 91 is not explicit regarding the use of specific medications. Section 61.53 under Part 61, which governs pilot certification in general, states the following:

²¹ Described, for example, in the following references: (a) Sansgiry, S.S., Cady, P.S., and Patil, S. 1997. "Readability of Over-the-Counter Medication Labels." *Journal of the American Pharmaceutical Association* NS37(5): 522-528. [September-October]. (b) Hanchak, N.A., Patel, M.B., Berlin, J.A., and Strom, B.L. 1996. "Patient Misunderstanding of Dosing Instructions." *Journal of General Internal Medicine* 11(6): 325-328. [June]. (c) Basara, L.R., and Juergens, J.P. 1994. "Patient Package Insert Readability and Design." *American Pharmacy* NS34(8): 48-53. [August]. (d) Watanabe, R.K., Gilbreath, K., and Sakamoto, C.C. 1994. "The Ability of the Geriatric Population To Read Labels on Over-the-Counter Medication Containers." *Journal of the American Optometric Association* 65(1): 32-37. [August].

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Establish and implement an educational program targeting train operating crewmembers that, at a minimum, ensures that all crewmembers are aware of the source of information described in Safety Recommendation R-00-2 regarding the hazards of using specific medications when performing their duties. (R-00-3)

Establish, in coordination with the U.S. Department of Transportation, the Federal Motor Carrier Safety Administration, the Federal Transit Administration, and the U.S. Coast Guard, comprehensive toxicological testing requirements for an appropriate sample of fatal highway, railroad, transit, and marine accidents to ensure the identification of the role played by common prescription and over-the-counter medications. Review and analyze the results of such testing at intervals not to exceed every 5 years. (R-00-4)

To the Federal Transit Administration:

Establish, with assistance from experts on the effects of pharmacological agents on human performance and alertness, procedures or criteria by which transit vehicle operators who medically require substances not on the U.S. Department of Transportation's list of approved medications may be allowed, when appropriate, to use those medications when operating transit vehicles. (R-00-5)

Develop, then periodically publish, an easy-to-understand source of information for transit vehicle operators on the hazards of using specific medications when operating transit vehicles. (R-00-6)

Establish and implement an educational program targeting transit vehicle operators that, at a minimum, ensures that all operators are aware of the source of information described in Safety Recommendation R-00-6 regarding the hazards of using specific medications when operating transit vehicles. (R-00-7)

Establish, in coordination with the U.S. Department of Transportation, the Federal Motor Carrier Safety Administration, the Federal Railroad Administration, and the U.S. Coast Guard, comprehensive toxicological testing requirements for an appropriate sample of fatal highway, railroad, transit, and marine accidents to ensure the identification of the role played by common prescription and over-the-counter medications. Review and analyze the results of such testing at intervals not to exceed every 5 years. (R-00-8)

**STATEMENT OF NICHOLAS A. SABATINI, ASSOCIATE ADMINISTRATOR
FOR AVIATION SAFETY, FEDERAL AVIATION ADMINISTRATION
BEFORE THE COMMITTEE ON TRANSPORTATION AND
INFRASTRUCTURE, SUBCOMMITTEE ON AVIATION, ON THE FAA'S
OVERSIGHT OF FALSIFIED AIRMAN MEDICAL CERTIFICATION
APPLICATIONS, ON JULY 17, 2007**

Chairman Costello, Congressman Petri, and Members of the Subcommittee, I am pleased to appear before you today to discuss the Federal Aviation Administration's oversight of the Airman Medical Certification application process. Let me assure you, at the outset, that the FAA takes this matter seriously, and we are very concerned about any falsification of information in our nation's aviation system. Let me also say that the vast majority of our nation's pilots are honest, dedicated, and have contributed significantly to our current unprecedented safety record. We support and are in the process of implementing the recommendations of the Inspector General on falsified airman medical applications, as I will discuss. We are also taking other proactive steps regarding this issue, which I will also discuss.

As you are aware, the Department of Transportation's Inspector General issued a report in 2005 describing the results of an investigation conducted jointly with the Social Security Administration's Inspector General, the United States Attorney's office for Northern California, and the FAA's Office of Aerospace Medicine, Western-Pacific Region, into the falsification of applications for FAA airman medical certificates. The investigation was known as "Operation Safe Pilot." I will not spend time discussing the details of the IG's findings, for they are already well known to you; however, I will discuss the IG's recommendations, and the FAA's response to those recommendations.

The Inspector General recommended that FAA work with the Social Security Administration (SSA) and other disability benefits providers, to develop and implement a strategy to conduct checks of applicants for airman medical certificates with the databases of SSA and other disability providers, and take appropriate enforcement actions where falsifications are found. The IG also recommended that FAA consider revising our Application for Airman Medical Certificate to require applicants to explicitly identify whether they are receiving medical disability benefits from any provider. I am pleased to inform you that the FAA is moving forward to implement both of the IG's recommendations.

FAA is working to develop a program, in cooperation with the Office of the Inspector General for the Social Security Administration (SSA), to cross-check randomly selected applicants for FAA airman medical certificates with the SSA disability database to determine if any applicants are receiving disability benefits from SSA. We hope to start by cross-checking applicants to the SSA database, because to receive SSA disability benefits, an individual must be totally disabled. Thus, virtually any applicant who is receiving SSA disability benefits will necessarily have a condition that would disqualify the applicant from holding an airman medical certificate from the FAA. We are still in discussions with the Social Security Administration, with the goal of signing a Memorandum of Understanding regarding the use of their database, and exactly what information the SSA will be able to divulge without violating privacy rules. Before we consider expanding the cross-checking of applicants to disability databases other than the

Social Security Administration, we have to consider the potential resources required to conduct investigations and make medical determinations regarding an applicant's disability and whether that condition disqualifies the applicant from holding an airman medical certificate.

In order to proceed with cross-checking applicants for airman medical certificates against the SSA disability database, or any other database, FAA must first revise the system of records notice for FAA's "Aviation Records on Individuals" to permit disclosure of the records through a routine use. This will require publishing a notice of the revised system of records in the Federal Register, and a period for public comments, before the records may be disclosed, and FAA can begin any cross-checking. This process may take six to twelve months to complete. However, we will immediately begin efforts to implement the IG's second recommendation, the addition of a question to the airman medical certificate application regarding disability benefits. The FAA will take appropriate administrative actions to change the application form to include the new question. Once that is completed, the new application form can be printed and distributed to Airman Medical Examiners (AME) nationwide.

We are proposing to change the Airman Medical Certificate application to add a question specifically asking if the applicant is receiving any disability benefits. While this additional question appears straightforward, the investigative work will begin after a positive response to the question. Once an applicant indicates that he or she is receiving disability benefits, FAA must then investigate to determine the disability benefits

provider, the condition for which the applicant is receiving disability benefits, and the extent of the applicant's disability. Social Security disability benefits, as I've already stated, are based on 100% disability, and would, presumably, disqualify the applicant from holding an airman medical certificate in virtually all cases. However, the Department of Veterans Affairs (VA) disability benefits, for example, cover a wide range of gradation from minor disabilities to total disability, and many conditions that would qualify for VA benefits would not necessarily disqualify the applicant from holding an airman medical certificate.

FAA is also being proactive in other areas regarding falsification of data on airman medical certificate applications. The FAA's Civil Aerospace Medical Institute (CAMI) has now developed an integrated Scientific Information System (SIS) that will provide a continuous monitoring of all airman medical certification records compared to aviation accidents or incidents and post-mortem toxicology reports. The FAA will therefore have the capability of continuously monitoring any aircraft accident and assessing any discrepancy between the pre-mortem certification and post-mortem findings. This includes prescription and non-prescription medications and medical abnormalities that could affect the ability to safely perform duties permitted by the airman certificate, which are related to National Transportation Safety Board causal accident factors.

In 2006, the FAA's Office of Aerospace Medicine initiated a routine process analysis study to evaluate and improve the efficiency of airman medical certification within the FAA. The Airman Medical Examiner (AME) Airman Certification Quality Assurance

study evaluated the accuracy of AMEs in determining the suitability of airman medical certification.

The review of 2000 records, randomly selected from 320,000 examinations, determined that 2.5 percent of records contained medical issues that should have resulted in the AME not issuing a certificate. However, further review indicated that most of these cases could have been issued if additional information was provided. In addition, 1.8 percent of the cases were submitted without enough information to determine if the airman should have been issued a certificate. Again, it was determined that most of these cases could have been issued if all information had been submitted.

Each of these proactive measures will assist the FAA in monitoring this issue. We are committed to expanding our efforts to review medical certificates and pursue appropriate enforcement actions when falsifications are discovered. Let me conclude, Mr.

Chairman, by stating that the FAA's first priority always has been, and always will be, safety. Safety is our agency's mission, and we have dedicated our careers to promoting safety. It is a responsibility we do not take lightly.

This concludes my statement, and I will be happy to answer any questions the Committee may have.



U.S. House of Representatives
Committee on Transportation and Infrastructure
 Washington, DC 20515

James L. Oberstar
 Chairman

John L. Mica
 Ranking Republican Member

David Heymsfeld, Chief of Staff
 Ward W. McCarragher, Chief Counsel

July 31, 2007

James W. Coon II, Republican Chief of Staff

The Honorable Nicholas A. Sabatini
 Associate Administrator for Aviation Safety
 Federal Aviation Administration
 800 Independence Avenue, S.W.
 Washington, D.C. 20591


Dr. Fredrick Tilton
 Federal Air Surgeon
 Federal Aviation Administration
 800 Independence Avenue, S.W.
 Washington, D.C. 20591

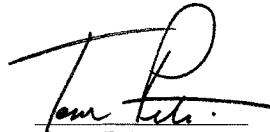
Dear Mr. Sabatini and Dr. Tilton:

On July 17, 2007, the Subcommittee on Aviation held a hearing on "FAA's Oversight of Falsified Airmen Medical Certificate Applications." Attached you will find additional questions that the Subcommittee would like you to answer.

I would appreciate your response within 14 days so that they may be included in the hearing record. Please send your response to: Leila Kahn, 586 Ford House Office Building, Washington, DC 20515. Due to delays in the receipt of mail in the mail screening process, I also request that you email and/or fax your response to Ms. Kahn at Leila.Kahn@mail.house.gov and (202) 226-6012. Should you have any questions or concerns, you may reach Ms. Kahn at (202) 226-4697.

Sincerely,


 Jerry F. Costello
 Chair
 Subcommittee on Aviation


 Thomas E. Petri
 Ranking Member
 Subcommittee on Aviation

**AVIATION SUBCOMMITTEE HEARING ON “FAA’S OVERSIGHT OF FALSIFIED AIRMAN MEDICAL
CERTIFICATE APPLICATIONS”
QUESTIONS FOR THE RECORD
JULY 17, 2007**

1. Have you ever taken administrative actions against a pilot for failing to report a medical condition on an airman medical certificate application even if the condition would not disqualify him from obtaining the certificate?
2. There are millions of people who drive cars and other personal vehicles with medical conditions that would disqualify a pilot. Why don’t we allow a pilot to fly with these same conditions?
3. In a 1990 rulemaking concerning reporting of drug and alcohol-related convictions, you stated that “a single impaired or intoxicated pilot could cause extensive and wide-spread damage to the public through loss of life or property damage.” Is this also the case with medical impairment?
4. A recent NPRM proposes to extend the duration of first- and third-class medical certificates for certain individuals. FAA claims a decrease in routine workflow which would allow the FAA to focus on the most safety-critical certification cases. Could these freed-up resources be used to process cases identified in the disability match.

Federal Air Surgeon’s Medical Airman Survey

1. Mr. Tilton, the most recent Federal Air Surgeon’s Medical Bulletin presents the results of the 2006 FAA Aerospace Medical Services Airman Survey. In this survey, 15 percent of airmen reported that an AME did not review their medical history. Of those, nearly 80 percent said no medical history review was done at all. Is this finding consistent with your AME requirements?
2. In the same survey, 4 percent of airmen reported that an AME did not conduct the physical exam. Of those responses, 13 percent said there was no physical exam. Can you comment on that statistic?
3. Do you believe that the survey results – which represent about 1 percent of currently certificated pilots – are representative of the pilot population as a whole?

DUI Information Required on the Airman Medical Certificate Application

1. In conducting the NDR match, does FAA rely on the airman social security number to match state records? If not, what data points are used?
2. How many airmen choose not to submit the social security numbers on their medical certificate applications?
3. How does FAA obtain DUI conviction information on airmen who do not submit the SSNs?

Responses to questions for the record by the The Honorable Nicholas A. Sabatini,
Associate Administrator for Aviation Safety
and
Dr. Fredrick Tilton, Federal Air Surgeon

1. **Have you ever taken administrative action against a pilot for failing to report a medical condition on an airman medical certificate application even if the condition would not disqualify him from obtaining the certificate?**

Intentionally failing to report a medical condition, even when it may not be specifically disqualifying, is a violation of Federal Aviation Administration (FAA) regulation (14 CFR § 67.403). When such a violation occurs we have the authority to suspend, revoke, or deny not only the medical certificate but all certificates and ratings a pilot may hold. According to our Enforcement Information System, in calendar year 2006, there were 333 cases in which we took legal enforcement action for violations of § 67.403.

2. **There are millions of people who drive cars and other personal vehicles with medical conditions that would disqualify a pilot. Why don't we allow a pilot to fly with these same conditions?**

The mental and physical skills required to act as a pilot of an aircraft are not the same as those required for driving a car or other personal vehicle. Piloting an aircraft requires a greater level of mental and physical skill. For this reason, the FAA has medical standards which a pilot applicant must meet in order to hold an FAA Medical Certificate. Medical certification has changed dramatically over the years in favor of the airman. Improved medical evaluation technology and treatments for conditions that otherwise may have been considered disqualifying continually affect how our licensing and credentialing programs are structured and modified. The program to medically certificate airmen has evolved to the point where certification for those persons who would not otherwise qualify is determined largely on a case-by-case basis. As it is with driving, however, the type of pilot privilege being exercised is always a factor. Commercial drivers must meet federal medical standards whereas non-commercial motor vehicle drivers must meet less rigid, state-imposed, qualification standards. By way of comparison to aviation we may make a determination, for example, that a private pilot with Type II diabetes may be authorized to exercise privileges whereas an airline transport pilot may not. The burden of proof of medical fitness rests with the pilot to demonstrate an ability to exercise privileges in a safe manner.

3. **In a 1990 rulemaking concerning reporting of drug- and alcohol-related convictions, you stated that "a single impaired or intoxicated pilot could cause extensive and wide-spread damage to the public through loss of life or property damage." Is this also the case with medical impairment?**

Yes, any impairment of a pilot whether medical in nature or not can be catastrophic. The potential for a catastrophic event would increase exponentially based on the severity of medical impairment. Fortunately, we do not see this as any type of normal occurrence; rather, our accident data reveal that this is a very rare occurrence. We credit this to the professionalism of pilots and to our medical certification process. Pilots understand that they must not fly when impaired; however, for those who would intentionally do so there is always the possibility of an accident or incident.

4. **A recent NPRM proposes to extend the duration of first- and third-class medical certificates for certain individuals. FAA claims a decrease in routine workflow which would allow the FAA to focus on the most safety-critical certification cases. Could these freed-up resources be used to process cases identified in the disability match?**

The NPRM claim of saved resources refers to our medical certification personnel, FAA physicians and support staff, having to process fewer applications. The intent of the NPRM, in part, is to free up resources for more time-consuming, safety-critical cases with complex medical histories such as those that require waivers, or “Special Issuances (SI).” These cases involve more paperwork, frequent interaction with the applicants, and, oftentimes, consultation with non-FAA medical experts. We initiated the NPRM in 2005, so any additional workload associated with a disability match was not accounted for in the development of the NPRM.

We agree that the proposed disability match will help to enhance the safety of the national airspace system. We will accomplish the disability match, and we will certainly take advantage of any freed-up resources in the processing of these cases. However, because we originally planned to use these resources to help us manage the workload associated with the SI cases, we anticipate that we will experience complaints from our SI recipients because the disability match will divert resources from the SI management process.

Federal Air Surgeon’s Medical Airman Survey

1. **Dr. Tilton, the most recent Federal Air Surgeon’s Medical Bulletin presents the results of the 2006 FAA Aerospace Medical Services Airman Survey. In this survey, 15 percent of airmen reported that an AME did not review their medical history. Of those, nearly 80 percent said no medical history review was done at all. Is this finding consistent with your AME requirements?**

No. Applicants are required to report their medical history on FAA Form 8500-8 and Aviation Medical Examiners (AME’s) are required to review that medical history before a medical certificate may be issued. Under FAA regulation

(14 CFR § 67.3) medical certificates are issued “based on medical examination and evaluation of a person’s history and condition.”

While it is difficult to determine definitively from the survey, we suspect that airmen who reported that an AME did not review their medical history with them, or that no history review was done at all, likely are airmen who did not report significant medical history. This is consistent with our finding that approximately 90% of applicants have insignificant medical backgrounds and are found eligible for the issuance of a medical certificate. Respondents may have considered a confirmation that they have no significant medical history as lack of a review of that history. With a routine case in a very busy physician’s office, sometimes individuals may feel that not enough time was spent and respondents may be voicing that frustration. It is interesting to note that, typically, the feedback we receive is that our process is overly rigid and that certification takes too long. Therefore, this indicator is noteworthy for us given that respondents seem to be inviting greater scrutiny, which is not typical feedback we receive.

We conduct this and other surveys with a view toward continuous improvement of the airman medical certification program and always discuss the results with AME’s at various AME seminars we conduct nationwide. We plan to highlight these findings at four upcoming AME seminars scheduled during this fiscal year.

2. **In the same survey, 4 percent of airmen reported that an AME did not conduct the physical exam. Of those responses, 13 percent said there was no physical exam. Can you comment on that statistic?**

These statistics raise concern and we are trying to decipher why these questions elicited such responses. It is for this reason we highlight this item in the most recent Federal Air Surgeon’s Medical Bulletin.

Airmen medical certificates may not be issued unless a medical examination is performed. AMEs are the only physicians credentialed and authorized under FAA regulation to perform examinations for airmen medical certification (14 CFR §§ 67.405, 183.11, 183.15, 183.21). Further, AMEs must certify, on Item 64 of FAA Form 8500-8, that they have “personally reviewed the medical history and personally examined the applicant.” To be sure, we also will highlight this finding prominently with our AME community in upcoming seminars. We suspect, and are trying to determine whether, respondents may have misrepresented or misinterpreted their particular experience when responding to the survey.

3. **Do you believe that the survey results-which represent about 1 percent of currently certificated pilots-are representative of the pilot population as a whole?**

We determined that of 15,755 surveys received by airmen, a total of 6,425 participated in the survey for an overall response rate of 41%.

While representative of a small fraction of the population of certificated U.S. pilots, the sample size is sufficient to draw valid statistical conclusions about the satisfaction of the overall population of pilots with aeromedical certification services offered on behalf of or by the FAA.

DUI Information Required on the Airman Medical Certificate Application

- 1. In conducting the NDR match, does FAA rely on the airman social security number to match state records? If not, what data points are used?**

The criteria that the FAA uses to match records with the National Driver Register database are the following:

Social Security Number (used as the primary match for NDR)
Date of Birth
Last Name, First Name

When a match occurs, the NDR provides the state driver's license number for us to query the specific state for the records.

- 2. How many airmen choose not to submit the social security numbers on their medical certificate applications?**

In calendar year 2006 we received 439,485 applications for airman medical certification. Of those, 106,429 applicants chose not to submit their social security number.

Total Applications (Exams) Submitted for Certification by the Class Requested for Calendar Year (CY) 2006:

Total Applications Received during Calendar Year 2006: 439,485
Total First Class Applications Received: 203,233
Total Second Class Applications Received: 95,101
Total Third Class Applications Received: 141,151

Total Applications (Exams) Submitted for Certification with Pseudo SSNs by the Class Requested for Calendar Year (CY) 2006:

Total Applications Received **with Pseudo SSNs** during Calendar Year 2006: 106,429
Total First Class Applications **with Pseudo SSNs** Received: 64,757
Total Second Class Applications **with Pseudo SSNs** Received: 23,528
Total Third Class Applications **with Pseudo SSNs** Received: 18,144

3. How does FAA obtain DUI conviction information on airmen who do not submit SSNs?

For airmen who are issued a pseudo SSN because they choose not to provide their actual SSN, the National Driver Register bases a match on airman name and date of birth only. When the airman's actual SSN is not provided, the number of false matches, and subsequent workload on the investigators, is increased since a match cannot be narrowed to a unique SSN number. In other words, we may receive multiple matches for a John Smith with the same birthdates; however, none of them may be a match to our airman.

**Before the Committee on Transportation and Infrastructure
Subcommittee on Aviation
United States House of Representatives**

For Release on Delivery
Expected at
10:00 a.m. EDT
Tuesday
July 17, 2007
CC-2007-063

Falsification of FAA Airman Medical Certificate Applications by Disability Recipients

**Statement of
Calvin L. Scovel III
Inspector General
U.S. Department of Transportation**



Mr. Chairman and Members of the Subcommittee:

We appreciate the opportunity to testify today regarding falsifications of the Federal Aviation Administration's (FAA's) "Application for Airman Medical Certificate." Pilots must have a valid Airman Medical Certificate before they are allowed to operate an aircraft. Our testimony today is primarily based on an investigation called "Operation Safe Pilot," which we conducted with the Social Security Administration's (SSA's) Office of Inspector General (OIG) and U.S. Attorney Offices (USAOs) in California, with assistance from FAA's Western Pacific Region Flight Surgeon and Chief Counsel offices.

At the outset, it is important to note that while the United States has the most complex aviation system in the world, it also is the safest. Multiple layers of controls in air carrier operations and maintenance processes, along with FAA's oversight, are largely responsible for the extraordinary level of safety that we have seen in the last 5 years.

Fraud committed against FAA's aviation safety programs has been an investigative priority for our office for more than 10 years. During that period we have investigated numerous schemes involving falsified maintenance records, fraudulent certifications for replacement parts, and fraudulently obtained pilot and mechanic certificates.

Operation Safe Pilot was initiated in 2003 consistent with the emphasis we have placed on investigating fraud schemes that impact aviation safety. It was a risk-based, targeted initiative (versus a random sample) based in part on a 2002 investigation conducted by OIG special agents in California. The investigation identified a private pilot who, for about 14 years, had been receiving SSA medical disability payments while at the same time maintaining his FAA-issued Airman Medical Certificate, which is required for issuance of a pilot certificate (aka, license).¹

This situation did not seem possible to us—someone who represented to FAA that he was medically fit to fly while at the same time claiming medical disability benefits. This appeared to indicate a serious gap between FAA's safety regulatory program and SSA's medical disability program, wherein one or the other program was being defrauded. To determine if this was indicative of a more widespread problem, we began Operation Safe Pilot, looking at a universe of about 40,000

¹ FAA-issued pilot certificates include: *Airline Transport* (pilots who can serve as pilot-in-command for a scheduled air carrier), *Commercial* (pilots who can fly for compensation or hire, including cargo), *Private* (pilots who fly for pleasure or personal business without accepting compensation), and *Student* (pilots who are being trained by an instructor for the purpose of obtaining their first full operating certificate).

pilots residing in Northern California. These pilots were part of a larger group of more than 600,000 pilots in the United States who held Airman Medical Certificates.

Of these 40,000 pilots, approximately 3,220 were found to be collecting some type of SSA benefits, including disability benefits. In coordination with SSA, FAA, and USAO officials, we focused our efforts on a smaller group of pilots receiving disability benefits and—following consultation with FAA—selected 48 pilots from this smaller group for investigation and potential prosecution, (a) recognizing that the USAOs could pursue at most 50 cases due to their own resource constraints, and (b) focusing on the most serious cases that the USAOs felt warranted criminal prosecution. It is important to note that Operation Safe Pilot was a criminal investigation and that it is not possible to substitute criminal investigations for regulatory enforcement, which we believe is generally the most appropriate way to police Airman Medical Certificate applications.

As a result of Operation Safe Pilot, the USAOs charged 45 of these 48 pilots with making false statements to FAA on their Airman Medical Certificate applications. All 45 pilots either plead guilty or were convicted at trial. Two pilots died during the investigation (both held commercial pilot certificates), one from complications stemming from his undisclosed medical condition and the other from causes that were not conclusively linked to that pilot's undisclosed condition. Prosecution by the USAO against another pilot was declined due to the pilot's severe mental incapacity.

In addition, the National Transportation Safety Board (NTSB) and FAA have documented hundreds of instances where pilots failed to disclose potentially disqualifying medical conditions. We believe such findings, when combined with the results of Operation Safe Pilot, reinforce the need to strengthen oversight of FAA's Airman Medical Certification Program. For example, on June 25, 2007, NTSB issued safety recommendations² to FAA identifying examples of pilots involved in accidents who had substance dependence histories, that FAA was or should have been aware of, that were not considered in the medical certification process. Similar to the circumstances identified in Operation Safe Pilot, NTSB's report highlighted problems with undisclosed medical conditions and the fact that other government agencies often have information relevant to FAA's medical certification decision-making process that FAA should access and use.

Mr. Chairman, my testimony today will address three key points essential to any discussion regarding how best to mitigate the safety risks posed by airmen who

² NTSB Safety Recommendation report; recommendation numbers A-07-41 through A-07-43.

falsify the Airman Medical Certificate application to conceal disqualifying medical conditions.

- The Airman Medical Certification Program is a key safeguard to ensure pilots are medically fit to fly;
- Operation Safe Pilot disclosed a potential systemic problem that requires greater attention and oversight by FAA; and
- FAA can take several actions to ensure that disabled pilots are not circumventing the medical certification process.

The Airman Medical Certification Program is a Key Safeguard to Ensure Pilots are Medically Fit to Fly

FAA requires that each pilot have a valid medical certificate before being allowed to operate an aircraft. To receive a medical certificate, pilots must complete an Airman Medical Certificate application³ and be examined by an FAA-designated Aviation Medical Examiner (AME)⁴. To a great extent, the medical certification process relies on an applicant's honesty in self-disclosing his or her medical history, especially any information about possibly disqualifying medical conditions. In other words, an AME's assessment to identify symptoms or medical conditions requiring further review is highly dependent on the medical history the applicant provides. Those who meet the appropriate medical standards—based on an in-person medical examination and an evaluation of medical history—are issued a medical certificate.⁵

Three classes of medical certificates exist: first, second, and third. The first-class certificate requires the most stringent medical examination, followed by the second-class, then the third-class, which is the least stringent of all the medical certificates. Airman Medical Certificate standards vary to accommodate all pilots, from those who fly aircraft in commerce to those who fly for pleasure. For example, airline transport pilots—who operate larger passenger aircraft—are required to hold a first-class medical certificate, must meet stricter health

³ FAA Form 8500-8, "Application for Airman Medical Certificate or Airman Medical and Student Pilot Certificate"

⁴ An AME is a medical doctor authorized by FAA to perform physical examinations for issuance of FAA Airman Medical Certificates.

⁵ The FAA medical examination is a general exam that reviews medical history (with attention to disqualifying medical conditions) and current medications; measures blood pressure, pulse, vision, and hearing; and includes a urine test. The examination is not designed to be a comprehensive physical.

standards, and are reexamined on a more frequent basis than private pilots who typically operate smaller aircraft not capable of carrying large numbers of passengers, and therefore are only required to maintain a third-class certificate.⁶

The Federal Air Surgeon also has identified certain medical conditions as specifically disqualifying for issuance of all classes of Airman Medical Certificates because these conditions could compromise a pilot's ability to safely operate an aircraft.⁷ These include conditions ranging from heart problems to neurological and psychiatric disorders, for which psychotropic drugs are often prescribed—the use of which in itself is disqualifying.

As of June 2007, FAA's database included 625,922 pilots with current Airman Medical Certificates, consisting of 111,222 certificates with first-class privileges, 118,250 with second-class privileges, and 396,450 with third-class privileges. During calendar year 2006, FAA received 439,390 Airman Medical Certificate applications, issued 421,106, and denied 5,947. Ninety-one percent of the denied applications (5,421) resulted from applicants who failed to provide additional information requested in conjunction with their application or to take other actions required by FAA, such as a letter from their doctor about a particular condition. FAA was awaiting additional information on the remaining 12,337 applications, which as of December 30, 2006, were still pending an issuance or denial decision.

Multiple Indicators Show Problems with Pilot Disclosures About Potentially Disqualifying Medical Conditions. In addition to Operation Safe Pilot, both NTSB and FAA have published reports reflecting that pilots did not disclose serious medical conditions, which sometimes resulted in accidents and fatalities. For example, a May 2006 FAA research report⁸ of post-mortem toxicology for 4,143 pilots who died in aviation accidents between 1993–2003 disclosed that 387 (nearly 10 percent) were taking some type of psychotropic, cardiovascular, or neurological medication not reported on their Airman Medical Certificate applications. The report's authors concluded that pilots who took psychotropic or neurological medications and were involved in fatal accidents rarely reported the medications or their underlying medical conditions to FAA.

In addition, our examination of the NTSB Aviation Accident/Incident Database, using keyword searches, identified 128 aircraft accidents attributable to pilot

⁶ Generally speaking, first-class certificates are valid for 6 calendar months after issuance, second-class certificates for 1 year, and third-class certificates for 3 years for pilots under age 40 or for 2 years age 40 and over.

⁷ Under certain circumstances, FAA may exercise discretionary authority—under special issuance provisions of Title 14, Code of Federal Regulations—to issue an Airman Medical Certificate to applicants with some of these conditions.

⁸ FAA, May 2006, *Comparison of Pilot Medical History and Medications Found in Postmortem Specimens* (Final Report), Civil Aerospace Medical Institute, Oklahoma City, OK.

medical issues (excluding substance abuse) over the last 11 years⁹ from a universe of 22,927 accidents. Examples of these accidents include the following:

- On January 31, 2004, while flying as a private pilot, a retired commercial airline pilot experienced an in-flight loss of control and crashed into the Pacific Ocean near San Pedro, California. Six months prior to the accident the pilot reported to FAA that he did not have a notable medical history and was not taking any prescription medication. However, a review of the pilot's medical records after the accident revealed he had multiple medical conditions, including severe heart disease and dementia. NTSB determined the cause of this fatal accident was "incapacitation" during descent, which resulted in the pilot's loss of control of his aircraft and an in-flight collision with water.
- On July 15, 2001, a private pilot lost control of his aircraft and died while flying near Bridgeville, Delaware. A post-crash review of his medical and pharmacy records disclosed a history of Hodgkin's disease, substantial damage to his gastrointestinal tract, hypothyroidism, gall bladder disease, and coronary artery bypass surgery. In addition, he required most of his calories to be delivered intravenously through a surgically placed port in his chest. However, on the pilot's most recent Airman Medical Certificate application, he disclosed only that he was taking a medication for hypothyroidism.

Toxicology reports indicated prescription antidepressant and narcotic-like painkiller medications in his blood at the time of the accident were more than 5 times higher than would be expected from the maximum recommended dosage. It was also discovered that the pilot was a doctor who wrote his own prescriptions. NTSB cited the cause of the accident as "incapacitation" due to the pilot's inappropriate use of medication and depression. NTSB also cited FAA's "inadequate certification/approval of the pilot's medical certificate" as a contributing factor.

Possible Regulatory Changes to Extend Medical Certificate Expiration Dates and Raise the Airline Pilot Retirement Age to 65 Underscore the Importance of the Medical Certification Process. On April 10, 2007, FAA published a Notice of Proposed Rulemaking¹⁰ to extend the period for which Airman Medical Certificates are valid. Specifically, for pilots under age 40, the validity of first-class certificates would be extended from 6 months to 12 months, and third-class

⁹ From January 1, 1996 through December 31, 2006.

¹⁰ FAA, "Modification of Certain Medical Standards and Procedures and Duration of Certain Medical Certificates," 72 FR 18092.

certificates from 3 to 5 years. Since extending certificate expiration dates will result in fewer opportunities for AMEs to evaluate pilot medical fitness, it will be even more important for FAA to take steps to ensure that pilots' medical conditions are fully disclosed when applications for Airman Medical Certificates are processed.

In addition, FAA is currently considering possible rulemaking action to change the mandatory retirement age for airline pilots from age 60 to age 65. Since the age limit is in part directly related to the health and medical condition of pilots, FAA actions to ensure compliance with disclosure requirements will be important in light of this potential change.

Many differing views may exist within the aviation industry and medical community regarding these possible rule changes. Notwithstanding the merits of these proposed changes, one thing is clear—if either rule change is made, ensuring the integrity of applicant disclosures on Airman Medical Certificate applications will become even more important for FAA in administering its Airman Medical Certification Program.

Operation Safe Pilot Disclosed a Potential Systemic Problem that Requires Greater Attention and Oversight by FAA

In 2003, our office initiated a proactive investigation, termed "Operation Safe Pilot," in part to determine whether a fraud scheme uncovered in 2002 reflected a systemic problem. During a 2002 joint criminal investigation in California with SSA/OIG, we determined a pilot had defrauded both FAA and the SSA Disability Insurance Trust Fund Program by making false statements to doctors for the purpose of maintaining his FAA private pilot's certificate and obtaining SSA benefits.

For approximately 14 years, this pilot had used two different doctors: one to conclude he was in good physical health in order to maintain his airman medical certificate and one to diagnose him with a disabling disease in order to fraudulently receive SSA benefits. In 2002, following a 4-day trial in Federal court, the pilot was found guilty of fraud. He was subsequently sentenced to serve 21 months in prison and 3 years of supervised release, as well as pay nearly \$200,000 in restitution to the Federal government. FAA also revoked his pilot's certificate and Airframe and Power Plant (A&P) mechanic's license.

Operation Safe Pilot began with a universe of about 40,000 pilots, residing in Northern California, who held current FAA-issued medical certificates. SSA compared these pilots against its databases and produced an initial list that identified approximately 3,220 pilots who were receiving some type of SSA benefits, including disability benefits. This list of pilots was further refined after seeking advice from the FAA Regional Flight Surgeon about what medical conditions might disqualify a pilot from holding an Airman Medical Certificate. Then, in consultation with USAOs in California, we selected potential investigative targets focusing on:

- Pilots collecting disability benefits from SSA's Disability Insurance Trust Fund and Supplemental Security Income Program;
- The apparent seriousness of the medical condition and falsification of the FAA Airman Medical Certificate application; and
- Cases meeting USAO prosecutive requirements.

At our request, the FAA Regional Flight Surgeon then reviewed SSA disability case files¹¹ and FAA medical files for selected pilots and, after doing so, provided us a written assessment for 48 regarding their medical qualification to hold an Airman Medical Certificate. The Flight Surgeon determined that these 48 pilots would not have passed the airman medical examination had the physicians conducting the examinations on behalf of FAA known about the pilots' disqualifying medical conditions. FAA issued Emergency Revocation Orders against 16 of these individuals and notified the remainder that their Airman Medical Certificates were being suspended.

Criminal prosecutions were initiated against these 48 pilots, who held all classes of pilot certificates.¹² Forty-five, including two medical doctors, were subsequently indicted for and convicted of making false statements to FAA on their Airman Medical Certificate applications.¹³ In all 48 cases, the pilots failed to notify FAA about their well-documented, severe, pre-existing medical conditions as required when completing and certifying the truthfulness of their Airman Medical Certificate applications.

¹¹ These files include physician evaluations, test results, and other medical evidence to support disability claims, as well as SSA initial and recurrent determinations of disability. In a few instances, SSA case files were not available for review. Alternatively, SSA provided other information describing the disabling conditions the disability recipients claimed.

¹² The 48 subject pilots ranged in age from 25 to 71, with an average age of 53 years, 7 months.

¹³ Two pilots died during the investigation, and the USAO declined prosecution against another pilot.

These pilots' pre-existing medical conditions included heart, back, and mental disorders and substance dependence. Many of these pilots had multiple disqualifying conditions, with the most common condition (approximately 54 percent) being some type of mental disorder such as schizophrenia. This illustrates the importance of ensuring that Airman Medical Certificate applicants fully disclose their medical history to AMEs as these types of disorders may not always manifest themselves during a general examination. Two examples of cases prosecuted as a result of Operation Safe Pilot are summarized below:

- An airline transport-rated pilot who flew cargo for a regional airline also received SSA disability benefits based on a diagnosis of schizophrenia and bipolar and psychotic disorders. The severity of this pilot's disability was illustrated by medical file notations made by his therapist when the pilot disclosed that voices were telling him to jump off the Golden Gate Bridge. In addition, in 1992, the pilot had been committed to a mental crisis unit after being apprehended for trespassing on the grounds of San Quentin State Prison, at which time he said he was under the control of voices directing him to hike until exhaustion.

However, when applying for FAA Airman Medical Certificates from 1991 to 2005, this pilot denied ever having any mental health disorder. He did not mention on any of these medical certificate applications his extensive history of mental illness, the doctors he visited, the institutions where he had been committed, or the medications he had been prescribed. At the same time, he did not mention the fact that he had been granted SSA disability benefits because he was deemed mentally incapable of maintaining any employment. He was prosecuted for making false statements on his Airman Medical Certificate application, and FAA revoked both his medical and airline transport pilot's certificates.

- A private pilot was receiving SSA disability benefits and 100% disability from the U.S. Department of Veteran Affairs based on a diagnosis of Post-Traumatic Stress Disorder and anxiety-related disorders. This pilot also had been convicted for misdemeanors involving fighting and domestic violence. In addition, he once told a doctor that he had previously attempted suicide. During an interview with a DOT/OIG special agent, the pilot admitted to previously being arrested for the manufacture and use of methamphetamines and for relapsing and failing a urine test for methamphetamines while on a pre-trial diversion program.

Nonetheless, when submitting applications for his Airman Medical Certificate in 2002 and 2004, he denied any mental disorders or criminal convictions. He was prosecuted for making false statements on these

applications, and FAA revoked both his medical and private pilot's certificates.

FAA Can Take Several Actions to Ensure that Disabled Pilots are Not Circumventing the Medical Certification Process

In July 2005, we sent a memorandum to the DOT Secretary, Deputy Secretary, and FAA Administrator highlighting the results of Operation Safe Pilot. We pointed out that FAA did not have a mechanism for (1) identifying certificated pilots who are receiving medical disability benefits from Federal disability providers such as SSA, the U.S. Department of Veterans Affairs, and the U.S. Department of Labor and (2) determining whether the documented medical conditions of those disability recipients would disqualify them from maintaining their Airman Medical Certificates. We recommended that FAA:

- Work with SSA and the other disability benefits providers to expedite development and implementation of a strategy to carry out these checks and take appropriate certificate regulatory enforcement action where falsifications are found; and
- Consider revising its "Application for Airman Medical Certificate" to require applicants to explicitly identify whether they are receiving medical disability benefits.

In the past, FAA has implemented improved controls to strengthen oversight of the Airman Medical Certification Program. For instance, as a result of FAA rulemaking activities initiated in the late 1980s, the medical certification process now requires use of the National Driver Register¹⁴ to help identify airmen whose driver's licenses were revoked or suspended because of driving while intoxicated to better detect undisclosed substance abuse. This action was taken, in part, in response to our February 1987 audit report¹⁵ that concluded that, procedurally, the Airman Medical Certification Program was overly dependent on self-reporting by pilots because 71–76 percent of pilots with prior convictions were not disclosing convictions for drug and/or alcohol problems.

¹⁴ The National Driver Register is a computerized database of information provided by State motor vehicle agencies about drivers who have had their licenses revoked or suspended or who have been convicted of serious traffic violations such as driving while impaired by alcohol or drugs.

¹⁵ DOT/OIG, "Report on Audit of Airmen Medical Certification Program," Report No. AV-FA-7-018.

Subsequent to this audit, OIG also conducted a proactive criminal investigative initiative, Operation Pilot Match, which resulted in prosecution of numerous pilots for falsifying their Airman Medical Certificate applications by failing to disclose convictions for drug- and/or alcohol-related offenses.

In response to our recommendations, in April 2007 FAA initiated discussions with SSA to match the FAA database of pilots with current medical certificates against relevant SSA databases of disability benefits recipients. Both agencies have been discussing how such a process could be structured under the Privacy Act to ensure compliance with the law. We understand that FAA plans to (a) revise its Privacy Act rules to specifically state that information collected may be shared with other agencies for the purpose of identifying undisclosed medical conditions, and (b) conduct periodic matches with SSA using the new process. We believe these are appropriate first steps and once FAA refines a matching process with SSA, it can begin developing similar processes with other Federal disability providers, such as the U.S. Department of Labor.

FAA has also expressed its intention to revise the "Application for Airman Medical Certificate" to explicitly ask the applicant about the receipt of medical disability benefits. To obtain maximum benefit from this action, FAA should ensure this question asks not only about the current receipt of medical disability benefits, but also about whether the applicant has ever received or submitted a claim for such benefits from any provider.

In conjunction with the foregoing actions, FAA should consider two additional measures:

- Conducting an education and outreach effort to ensure pilots are fully aware of their responsibilities for accurately disclosing their medical histories on the Airman Medical Certificate application and discussing their histories with AMEs during periodic medical examinations.
- Administratively offering a grace period to hold harmless any pilots who self-identify to the FAA previously undisclosed and potentially disqualifying medical conditions. Such a measure could be designed to relieve pilots of fines and other penalties associated with violating certain FAA regulations, thereby providing an incentive for them to participate.¹⁶ FAA would need to make absolutely clear that all medical conditions disclosed would be evaluated, and, unless pilots were found to be medically

¹⁶ FAA previously offered a similar program in the late 1980s to identify previously undisclosed drug- or alcohol-related convictions, resulting in more than 11,000 pilots making disclosures.

fit to fly, their Airman Medical Certificates would be subject to revocation. We believe such a measure would provide an immediate opportunity to prospectively mitigate the safety risk posed by undisclosed and potentially disqualifying medical conditions.

This concludes my statement, Mr. Chairman. I would be pleased to address any questions that you or other Members of the Subcommittee may have.

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U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

July 31, 2007

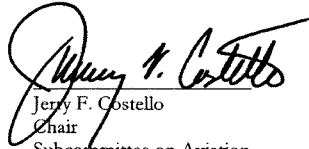
The Honorable Calvin L. Scovel, III
Inspector General
U.S. Department of Transportation
400 Seventh Street, S.W.
Washington, D.C. 20590


Dear Inspector General Scovel:

On July 17, 2007, the Subcommittee on Aviation held a hearing on "FAA's Oversight of Falsified Airmen Medical Certificate Applications." Attached you will find additional questions that the Subcommittee would like you to answer.

I would appreciate your response within 14 days so that they may be included in the hearing record. Please send your response to: Leila Kahn, 586 Ford House Office Building, Washington, DC 20515. Due to delays in the receipt of mail in the mail screening process, I also request that you email and/or fax your response to Ms. Kahn at Leila.Kahn@mail.house.gov and (202) 226-6012. Should you have any questions or concerns, you may reach Ms. Kahn at (202) 226-4697.

Sincerely,


Jerry F. Costello
Chair
Subcommittee on Aviation


Thomas E. Petri
Ranking Member
Subcommittee on Aviation

**AVIATION SUBCOMMITTEE HEARING ON "FAA'S OVERSIGHT OF FALSIFIED AIRMAN MEDICAL
CERTIFICATE APPLICATIONS"
QUESTIONS FOR THE RECORD
JULY 17, 2007**

1. What do you estimate it costs per prosecution resulting from Operation Safe Pilot? Would FAA likely incur similar costs if they were to pursue administrative sanctions? If not, what would account for the differences?
2. Your recommendations include matching disability databases and the database of airman medical certificates. There are many individuals that manifest serious conditions such as cardiovascular disease and mental disorders that are not receiving disability. How do we catch those individuals if they lie on their applications? Why is your focus on disability recipients?
3. During Operation Safe Pilot, did you find that the falsifications were more prevalent in the general aviation community? Did you find cases where cargo or air transport pilots were not being truthful? Do these pilots pose a higher safety risk than GA pilots?
4. It is my understanding that the number of cases that were brought to prosecution under Operation Safe Pilot was somewhat arbitrary, based on the resources available to the U.S. Attorney's Office and your office. But do you have any estimates for the scope of the falsification problem? Is there any evidence that it is systemic?
5. Cross-checking pilots' medical certificate applications with the Social Security Administration's disability benefits records seems like a great way to catch those who are double-dipping. What obstacles is the FAA likely to meet in continuing these types of cross-checks that were the basis of your investigation? Are there privacy issues? Has there been any progress in getting over those obstacles?

Responses to questions for the record by the DOT Inspector General, The Honorable
Calvin L. Scovel, III
Aviation Subcommittee Hearing
on
“FAA’S Oversight of Falsified Airman Medical Certificate Applications”
Questions For The Record
July 17, 2007

Question 1. What do you estimate it costs per prosecution resulting from Operation Safe Pilot? Would FAA likely incur similar costs if they were to pursue administrative sanctions? If not, what would account for the differences?

Answer. The cost to the Office of Inspector General (OIG) of pursuing Operation Safe Pilot was \$401,192. This includes amounts charged to direct labor hours, general and administrative overhead, travel costs, and other direct costs. This cost figure does not include FAA or U.S. Attorney Office (USAO) costs.

Our cost per prosecution was \$8,915 for the 45 cases prosecuted. Note: We referred 48 cases to the USAO for prosecutive consideration; however, 2 pilots died before the USAO could bring charges and the USAO declined prosecution for another due to that pilot’s severe mental incapacitation. We do not have a basis to say what costs FAA would likely incur if they were to pursue administrative sanctions in similar cases.

Question 2. Your recommendations include matching disability databases and the database of airman medical certificates. There are many individuals that manifest serious conditions such as cardiovascular disease and mental disorders that are not receiving disability. How do we catch those individuals if they lie on their applications? Why is your focus on disability recipients?

Answer. We focused on disability recipients with potentially disqualifying medical conditions because they were representing to FAA that they were medically fit to fly while at the same time claiming medical disability benefits from the Social Security Administration (SSA). This appeared to indicate a serious gap between FAA’s safety regulatory program and SSA’s medical disability program, wherein one or the other program was being defrauded by the submission of falsified documentation.

Focusing on these disability recipients allowed us to (1) conduct Operation Safe Pilot using a risk-based, targeted approach given the limited investigative resources available and (2) use existing documentation in determining whether the medical conditions of those disability recipients would disqualify them from maintaining their Airman Medical Certificates.

Random sampling was another approach we could have used to potentially catch individuals who make false statements to FAA on their Airman Medical Certificate applications but are not receiving SSA medical disability benefits; however, this would have been more labor intensive.

Question 3. During Operation Safe Pilot, did you find that the falsifications were more prevalent in the general aviation community? Did you find cases where cargo or air transport pilots were not being truthful? Do these pilots pose a higher safety risk than General Aviation pilots?

Answer. The 45 cases prosecuted by the USAO as a result of Operation Safe Pilot included pilots with all types of FAA pilot certificates, except Sport and Recreational pilot certificates. Specifically:

- Airline Transport — 4 (9%) — pilots who can serve as a pilot-on-command for a scheduled airline.
- Commercial — 6 (13%) — pilots who can fly for compensation or hire, including cargo.
- Private — 28 (62%) — pilots who fly for pleasure or personal business without accepting compensation for flying.
- Student — 7 (16%) — pilots who are being trained by an instructor for their first full certificate.

These numbers should not be construed as indicating which particular category of pilot certificate holders is most likely to falsify FAA Airman Medical Certificate applications for two reasons. First, Operation Safe Pilot was a risk-based, targeted initiative as opposed to a statistically projectable random sample. Second, after coordination with SSA and FAA, and in consultation with the USAOs, we selected potential investigative targets focusing on:

- Pilots collecting disability benefits from SSA's Disability Insurance Trust Fund and Supplemental Security Income Program;
- The apparent seriousness of the medical condition and falsifications of the FAA Airman Medical Certificate application; and
- Cases meeting USAO prosecutive requirements (i.e., basically open and shut cases).

Generally speaking, we believe that airline and cargo pilots with disqualifying medical conditions pose a higher safety risk than general aviation pilots. First, there are more of them. Airline Transport (144,822) and Commercial (130,959) pilot certificate holders represent approximately 46 percent of the just over 600,000 active pilots in the United States today. Private or general aviation pilots number 237,970 or about 40 percent of pilot certificate holders.

Second, airline and commercial (or cargo) pilots (1) fly much larger airplanes with more fuel and passengers than general aviation or private pilots, and (2) fly more often (sometimes daily) than general aviation or private pilots who sometimes only once or twice a month.

We do, however, know private planes piloted by pilots with disqualifying medical conditions have crashed with horrifying results, so the potential safety risk is not just with airline and cargo pilots. For example, on November 26, 1999, a small Beechcraft Bonanza aircraft crashed into a residential neighborhood in Newark, New Jersey killing all 3 passengers and injuring 25 people on the ground—two of them critically. Eighteen buildings were damaged as the force of the impact knocked plaster off of the walls and ceilings in nearby apartment buildings, displacing 50 families. Eleven cars were damaged or destroyed by fire. In all, the City of Newark estimated the property damage to exceed \$1.2 million.

Question 4. It is my understanding that the number of cases that were brought to prosecution under Operation Safe Pilot was somewhat arbitrary, based on the resources available to the U.S. Attorney's Office and your office. But do you have any estimates for the scope of the falsification problem? Is there any evidence that it is systemic?

Answer. Because (1) we have not conducted a full-blown audit of the Airman Medical Certification Program, and (2) Operation Safe Pilot was a risk-based, targeted initiative as opposed to a statistically projectable random sample, we cannot say with certainty what the scope of the falsification problem is.

Question 5. Cross-checking pilots medical certificate applications with the Social Security Administration's disability benefits records seems like a great way to catch those who are double-dipping. What obstacles is the FAA likely to meet in continuing these types of cross-checks that were the basis of your investigation? Are there privacy issues? Has there been any progress in getting over those obstacles?

Answer. In April 2007 FAA initiated discussions with SSA to match the FAA database of pilots with current medical certificates against relevant SSA databases of disability benefits recipients. Both FAA and SSA have been discussing how such a process could be structured under the Privacy Act to ensure compliance with the law. We understand that FAA plans to revise its Privacy Act rules to specifically state that information collected may be shared with other agencies for the purpose of identifying undisclosed medical conditions.

FAA - 2006 Survey of Satisfaction with the Aviation Medical Examination Process

Sample size =6425 (1 percent of pilot population)

	<u>Did not have Medical History Done by AME</u>		<u>Did not have Physical Exam Done by AME</u>	
Survey Results (6425)	964	15%	257	4%
Extrapolated Results (w/ 5% variance) (625,000 airmen)	89,063	15%	23,750	4%

This Analysis was performed by Committee Staff and the extrapolation has not been reviewed by FAA



Federal Air Surgeon's Medical Bulletin

FAA Survey

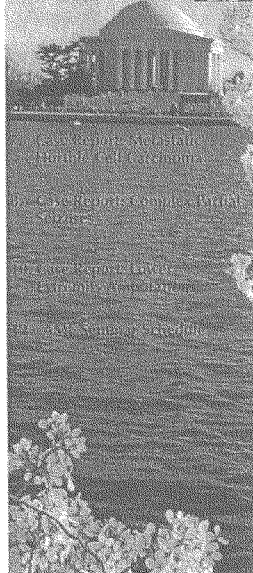
Vol. 45, No. 2
2007-2

Aviation Safety Through Aerospace Medicine
For FAA Aviation Medical Examiners, Office of Aerospace Medicine Personnel,
Flight Standards Inspectors, and Other Aviation Professionals.

U.S. Department of Transportation
Federal Aviation Administration

HEADS UP →

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3. New Regional Flight Surgeon in Southern
4. Certification Updates, Issues and Answers
6. OAM News
- HQ Manager Selected
- Annual OAM Awards Ceremony Held



QUICK FIX Pilot Feedback on Aviation Medical Examiners

By Richard 'Dick' Jones, MD

PROBLEM

Results of the 2006 FAA Aerospace Medical Services Airman Customer Satisfaction Survey are in! A total of 15,755 surveys were received by airmen and 6,425 were returned, a 41% response rate. There were many interesting findings in these results that we can cover another time in this space, but today I want to focus on only a couple of problem areas.

Fifteen per cent of airmen responded "No" when asked, "Did the aviation medical examiner (AME) with whom you had the appointment review your medical history with you?"; 7% said the history was reviewed by a non-AME physician, 15% by a non-physician, and the remaining 79% said there was no history review. Four per cent of airmen reported their evaluations were not done by the person with whom they had the appointment; of these, 70% were done by non-physicians, 17% by a non-AME physician, and 13% said they were not examined at all.

Continued on page 3

AME Independent Medical Sponsors Needed Training Available for Treating Substance Abuse in Pilots

By Michael A. Berry, MD

The Federal Aviation Administration needs more experienced aviation medical examiners to become trained as Independent Medical Sponsors for the Human Intervention Motivation Study, better known as the HIMS program. There are many portions of the country with few or no such aviation medical examiners. The continued success of this extremely important safety program is dependent on experienced, well-trained AMEs.

Background

HIMS was initiated in the early 1970s in the industrial setting because it is the most effective place to intervene in the addiction process. The program grew out of a study grant from the National Institute for Alcohol Abuse and Alcoholism and the Air Line Pilots Association. The

HIMS concept is based on a cooperative and mutually supportive relationship between pilots, the Federal Aviation Administration, and management to effectively address the problem of substance abuse in pilots. With proper treatment, the rehabilitation of airline pilots with alcohol or substance abuse problems can be successful and cost-effective.

The major components of the FAA program are: diagnosis by an trained addiction professional, treatment, comprehensive continuing care, long-term monitoring, and total abstinence from alcohol. A pilot must be evaluated and monitored by an experienced and specially trained aviation medical examiner who acts as the pilot's sponsor.

Continued on page 3

Susan E. Northrup, MD, MPH

A Biography of the New Southern Regional Flight Surgeon



DR. SUSAN E. NORTHRUP, recently selected by the Federal Air Surgeon as the Southern Regional Flight Surgeon, was born in Dayton, Ohio, and graduated from The Ohio State University in 1985 with a commission via the Air Force Reserve Officer Training Corps. She graduated from The Ohio State University College of Medicine in 1989 and interned in Family Medicine at The Ohio State University Hospital in 1990.

She then entered active duty at Moody AFB, Ga., and earned a Masters of Public Health degree from the University of Texas in 1994, the USAFSAM Residency in Aerospace Medicine in 1995, and the USAFSAM Occupational Medicine Residency in 1996. She obtained the

American Board of Preventive Medicine's certification in both specialties.

A colonel in the U.S. Air Force Reserve, Dr. Northrup has more than 600 hours of flying. Prior assignments include Chief of Operational Medicine for the USAF at Bolling AFB, Chief of Aerospace Medicine at Pope AFB, N.C., and as Flight Surgeon for the 69th Fighter Squadron, Moody AFB, Ga., during and after *Desert Storm*.

She transitioned to the USAF Reserve in 2001 as the Reserve Consultant for the HQ ARFC/SGP. Her civilian position until 2005 was as Delta Air Lines' regional medical director for air crew and passenger health services. Since 2005 she performed Reserve duties as the Chief, Reserve Consultant to the Chief of Clinical Services, Air Force Reserve Command and the Chief of the Reserve Line of Duty Board.

Active in professional organizations, Dr. Northrup is a Fellow of the Aerospace Medical Association, co-chairs their scientific program and registration committees, and a member

of several other committees. She has been elected to the American Board of Preventive Medicine as one of the three aerospace medicine members. She is the president-elect of the Civil Aviation Medical Association and editor of their *FlightPhysician* newsletter.

In addition, she is a member of the International Academy of Air and Space Medicine, the Society of United States Air Force Flight Surgeons, the Reserve Flight Surgeons Association, the Airline Medical Directors Association, the American Medical Association, the American College of Preventive Medicine, the American Legion, and the Reserve Officer Association. From 2002 to 2005, she chaired the medical committee of the Air Transport Association, setting airline industry standards and medical response plans for the U.S. carriers.

A private pilot and the co-owner of a Harvard Mark IV Warbird, Dr. Northrup lives in Peachtree City, Ga., with her husband and their two sons.



QUICK FIX from page 1

RESULT

We have long received anecdotal reports from pilots that we have AMEs in our system who do not perform examinations up to FAA standards. We now have some quantification of the problem. It is particularly disturbing that airmen are having medical examinations and histories done by non-physicians and non-AMEs. This practice is a direct violation of federal regulations, which stipulate that all FAA examinations must be performed by AMEs and that AMEs must be physicians. When it comes to our attention that an examination has been done by someone

other than an AME, the examination must be repeated by another AME and we investigate the AME whose practice was involved for other similar instances of policy violations.

SOLUTION

All AMEs must ensure they personally perform examine all applicants for whom they issue a medical certificate and personally review each medical history with the applicant. Any deviation from this policy will warrant termination of the responsible AME's designation.



Dr. Jones manages the Civil Aerospace Medical Institute's Aerospace Medical Education Division.

AME SPONSORS from page 1

HIMS Training

The next HIMS training seminar will be conducted in Denver, Colo., September 10-12, 2007. If you are interested in attending or would like more information about becoming an AME Independent Medical Sponsor, please contact:

Michael A. Berry, MD
FAA Headquarters, AAM 200
800 Independence Ave., SW
Washington, DC 20591
(202) 267-8035



Dr. Berry manages the Medical Specialties Division at Federal Aviation Administration headquarters in Washington, D.C.

DEPARTMENT OF TRANSPORTATION**Federal Aviation Administration****14 CFR Parts 61 and 67**

[Docket No. 25905; Amdt No. 61-87, 67-14]

RIN 2120-AC51

Pilots Convicted of Alcohol- or Drug-Related Motor Vehicle Offenses or Subject to State Motor Vehicle Administrative Procedures**AGENCY:** Federal Aviation Administration (FAA), DOT.
ACTION: Final rule.

SUMMARY: This final rule sets forth regulations under which the FAA may deny an application for, and suspend or revoke, an airman certificate or rating if an individual has had two or more alcohol- or drug-related motor vehicle convictions or state motor vehicle administrative actions within a 3-year period (motor vehicle actions). The rule requires pilots to report to the FAA in Oklahoma City, Oklahoma, all alcohol- or drug-related motor vehicle convictions or state motor vehicle administrative actions that occur after the effective date of the final rule. The rule also amends the FAA's medical certification rules to include an "express consent" provision that authorizes the FAA to obtain information from the National Driver Register.

The rule is needed to prohibit a pilot from operating an aircraft after multiple alcohol- or drug-related motor vehicle actions. It is also needed to verify traffic conviction information required to be reported on the airman medical application and to evaluate whether the airman meets the minimum standards to be issued an airman medical certificate. The rule is intended to enhance safety in air travel and air commerce, and is necessary to remove from navigable airspace pilots who demonstrate an unwillingness or inability to comply with certain safety regulations and to assist in the identification of personnel who do not meet the medical standards of the regulations.

EFFECTIVE DATE: November 29, 1990.

FOR FURTHER INFORMATION CONTACT: Mr. Robert Covell, Investigations and Security Division (ACS-310), Office of Civil Aviation Security, Federal Aviation Administration, 800 Independence Avenue, SW, Washington, DC 20591; telephone (202) 267-3965.

SUPPLEMENTARY INFORMATION:**Background****General Statement**

The Federal Aviation Regulations (FAR) have addressed the issues of alcohol and drug use by an aircraft crewmember for many years. Section 91.11 of the FAR, for example, provides for certificate action against a person who acts, or attempts to act, as a crewmember of a civil aircraft within 8 hours after consumption of an alcoholic beverage; while under the influence of alcohol; while using any drug that affects the person's faculties in any way contrary to safety; or while having 0.04 percent by weight or more alcohol in the blood. Moreover, the FAA's strong interest in ensuring that airmen are not alcohol or drug dependent is demonstrated by the medical standards contained in part 67. This rule will supplement, not replace, the current regulations. It is intended to implement measures to further ensure the safety of air commerce. This will be accomplished by identifying and removing from airspace those persons who may commit unsafe acts in an aircraft because of a disregard for certain safety regulations; by identifying those persons who fail to report violations of specific safety regulations to the FAA as required; and by providing a means for verification of information or omission of information required to be reported on the application for airman medical certification.

Regulatory History

The FAA issued a notice of proposed rulemaking (NPRM) concerning pilots convicted of alcohol- or drug-related motor vehicle offenses or subject to state motor vehicle administrative procedures on May 11, 1989 (54 FR 21550; May 18, 1989). This NPRM was issued in part to respond to the results of an audit of the FAA's airman medical certification program by the Office of the Inspector General (OIG) of the U.S. Department of Transportation (DOT) released on February 17, 1987. The OIG evaluated the procedures used by the FAA to determine if pilots applying for medical certification had reported alcohol- or drug-related motor vehicle convictions on the FAA medical application form. This information and other historical data are required of applicants for medical certification to assist the agency in determining their physical and psychological fitness to safely operate an aircraft.

The OIG used three automated files to conduct its audit: (1) An extract from a state driver licensing file on alcohol- and drug-related motor vehicle offenses;

(2) an extract from the National Driver Register (NDR); and (3) the FAA's airman medical file (the Automated Medical Certification Data Base). The OIG used these files to perform two comparisons for the audit. First, the OIG compared the FAA's medical file and the state records of alcohol- and drug-related traffic offenses. This comparison showed that 1,554 of the active pilots (3.4 percent) who held a driver's license issued by the state had at least one driving-while-intoxicated (DWI) or driving-under-the-influence (DUI) conviction. Of these pilots, 1,124 pilots (71 percent) did not report this information to the FAA.

The OIG also compared the FAA's medical file with the NDR records for individuals whose driver's licenses had been suspended or revoked based on alcohol- or drug-related traffic offenses. This comparison disclosed that the driver licenses of approximately 10,300 of the 711,848 active airmen (1.45 percent) had been suspended or revoked for DWI or DUI offenses within the past seven years. Of these pilots, 7,850 pilots (76 percent) failed to report these motor vehicle convictions to the FAA on their medical applications. The National Driver Register Act of 1982 (NDR Act) contains statutory restrictions regarding access and use of NDR information. Thus, the OIG collected only statistical data from the NDR and did not obtain the names of specific airmen during the audit.

After the audit report was released, the OIG announced its intention to conduct two computer matches as part of an investigative effort to gather specific, detailed information (52 FR 5374; February 20, 1987) (52 FR 6545; March 18, 1987). For the first match, the OIG matched the FAA's airman medical file with certain identification records of criminal history information of the Federal Bureau of Investigation (FBI). For the second match, the OIG matched FAA's Automated Medical Certification Data Base with the State of Florida Department of Highway Safety and Motor Vehicles driver licensing records for alcohol- or drug-related traffic offenses. These one-time computer matches resulted in the identification of specific airmen who allegedly falsified applications for medical certificates by failing to report alcohol- or drug-related convictions.

The OIG reported the results of the Florida state match and the Department of Justice (DOJ) match to the FAA for possible administrative action and to the DOJ for possible criminal action based on a violation of 18 U.S.C. 1001 for intentional falsification of an application for a medical certificate.

Based on the information discovered during the audit, the OIG recommended that the FAA develop an objective, regulatory standard that would provide for FAA certificate action against pilots convicted of alcohol- or drug-related motor vehicle offenses. The OIG also recommended that the FAA seek legislative changes to the NDR statute that would give the FAA access to NDR information. The National Transportation Safety Board (NTSB) and the U.S. General Accounting Office (GAO) supported these recommendations. On December 30, 1987, the President signed legislation amending the NDR Act to add section 206(b)(3) (Pub. L. 100-223; 101 Stat. 1525). In part, that statutory amendment authorizes the FAA to receive information from the NDR regarding motor vehicle actions that pertain to any individual who has applied for an airman medical certificate.

The amendment to the NDR Act states:

Any individual who has applied for or received an airman's certificate may request the chief driver licensing official of a State to transmit information regarding the individual * * * to the Administrator of the Federal Aviation Administration. The Administrator of the Federal Aviation Administration may receive such information and shall make such information available to the individual for review and written comment. The Administrator shall not otherwise divulge or use such information, except to verify information required to be reported to the Administrator by an airman applying for an airman medical certificate and to evaluate whether the airman meets the minimum standards as prescribed by the Administrator to be issued an airman medical certificate. There shall be no access to information in the Register under this paragraph if such information was entered in the Register more than 3 years before the date of such request, unless such information relates to revocations or suspensions which are still in effect on the date of the request." [23 U.S.C. 401 note]

On October 22, 1987, the FAA issued a notice (52 FR 41557; October 29, 1987) of a special enforcement policy regarding applicants for a medical certificate who have provided incorrect information about traffic convictions on a medical application form. In order to encourage compliance with the reporting requirement on the medical certificate application form, and to ensure that the FAA's records are accurate and complete, the FAA afforded airman an opportunity to avoid FAA enforcement action based on falsification of their medical certificate applications if they volunteered the corrected information to the FAA before January 1, 1988. As of that date, the FAA may take

enforcement action, based on falsification of the medical certificate application, against those persons who had not provided corrected information. This includes those persons identified and referred by the OIG and those persons discovered through the FAA investigative process. However, even after January 1, 1988, the FAA determined not to take enforcement action against those persons who submitted corrected information prior to the FAA obtaining that information from other sources. On October 27, 1988, the FAA issued a notice announcing complete termination of this so-called "amnesty" policy, effective December 1, 1988 (53 FR 44168; November 1, 1988). Therefore, after November 30, 1988, voluntary submission of corrected information does not preclude FAA enforcement action.

The FAA received about 11,300 letters from pilots disclosing offenses previously unreported on their medical application forms in response to the October 1987 notice. The "disclosure" letters served in most cases to secure amnesty from FAA enforcement action for these airmen as related to the falsification issue. The disclosures, however, did not preclude the FAA from denying an application or suspending or revoking a medical certificate, as appropriate, after evaluating the disclosures and determining that an airman was medically not qualified.

Airmen whose traffic offenses suggested the need for further medical evaluation were asked to provide the agency with all court or administrative records associated with the offenses, or records associated with any care or treatment for substance abuse or related disorders. They also were asked to undergo specialized medical evaluations, if appropriate. The airman medical files of the individuals who submitted the information were updated and reevaluated in light of the new information to ascertain whether those airmen continued to be medically qualified to operate an aircraft in a safe manner.

Since October of 1987, the FAA has reviewed approximately 24,000 airman medical files as a result of letters from pilots disclosing offenses previously unreported and of new applications for medical certificates indicating DWI or DUI convictions. The majority of the pilots whose files were reviewed were sent letters confirming their continued eligibility to hold medical certificates. Of the 24,000 airmen, approximately 2,400 (10 percent), were requested to submit additional information. Of this 2,400 airmen, an estimated 24 (1 percent) were denied medical certificates or had

their medical certification suspended or revoked.

On April 11, 1989, the FAA issued another notice of enforcement policy (54 FR 15144; April 14, 1989). This notice announced the FAA's enforcement policy in those OIG-referred cases in which the airman had not come forward to disclose the convictions pursuant to the amnesty policy, as well as in similar cases which otherwise may come to the FAA's attention. In all cases, the FAA reviews the individual's medical eligibility, and takes action, if appropriate, whether or not the FAA takes certificate action based on falsification.

Discussion of Comments

General Statement

The FAA received 84 timely comments in response to the May 18, 1989, NPRM. Based on its analysis and review of these public comments, the FAA is adapting some of the proposed revisions to parts 61 and 67, with changes as described. A discussion of the comments follows.

In general, the majority of the commenters support the safety goal of the proposed rule. Those objecting say that the methods proposed by the FAA in the NPRM do not contribute to a safer aviation community, but rather place serious regulatory burdens on those airmen who are law-abiding. Among the commenters are six organizations representing airline and pilot associations; one Federal agency, the NTSB; and seventy-seven individual members of the flying and non-flying public. The organizations include the Air Line Pilots Association (ALPA), the Aircraft Owners and Pilots Association (AOPA), the Experimental Aircraft Association (EAA), the Helicopter Association International (HAI), the National Air Transportation Association (NATA), and the National Business Aircraft Association, Inc. (NBAA).

Specific Comments

Existing Laws and Regulations

Nine commenters note that the FAA already has safety and enforcement regulations in existence. They believe the FAA should enforce rather than promulgate additional regulations. In the words of one respondent, "[t]he rules of the road are not the same as the rules of the air * * * Alcohol is allowed up to a certain amount, while driving a car. In the case of operating an airplane, no alcohol at all is the regulation."

The FAA agrees with the need to enforce existing safety regulations. Several commenters indicate that the

rules dictating "within 8 hours" or "under the influence" are already in place and are designed to protect the public from intoxicated pilots; the agency devotes considerable resources to this purpose. However, the previously described OIG audit shows that although only a small percentage of the aviation community may be involved, there are airmen who do not comply with the existing reporting requirements. There also are some airmen who have a record of multiple convictions for DWI and DUI, indicating that not all pilots show an appropriate concern for critical highway safety requirements. It is these pilots who are the focus of the detection mechanisms established by this rule.

Lack of Supportive Evidence of Correlation

Of concern to twenty-six commenters, including all six organizations, is the lack of statistical data to support the proposals presented in the NPRM. They note the lack of a proven correlation between alcohol and drug convictions while driving a motor vehicle and alcohol- and drug-related accidents while flying an aircraft.

The FAA made no attempt to obscure the lack of evidence correlating alcohol- or drug-related motor vehicle actions with substance abuse-related accidents or incidents while operating an aircraft. The FAA notes, however, that from 1978 to 1987, 8.0 percent of general aviation pilots killed in aviation accidents had a blood alcohol level of 0.04 percent or more. During that same period, 11,213 people died in general aviation accidents. If the rule were to result in the saving of a few lives, the potential benefits of the rule would exceed its potential cost.

If, for example, 8.0 percent of average annual deaths in general aviation accidents occurred in circumstances where alcohol may have been a contributing factor and the rule were only one percent effective in preventing such accidental deaths, then the benefits of the rule (given the values currently ascribed to a statistical life) would exceed its potential costs. FAA believes, in fact, that the rule will be significantly more effective than one percent so that potential benefits are likely to significantly exceed costs.

Therefore, FAA needs to develop an objective, regulatory standard that will enable the agency to take certificate action against pilots convicted of alcohol- or drug-related motor vehicle offenses. Similarly, the FAA has a clear safety basis for ensuring that an applicant for a medical certificate fully and accurately completes the application so that the individual can be

evaluated in accordance with the medical standards.

In light of the FAA's statutory mandate to protect and enhance aviation safety, the FAA elects to adopt the majority of the proposals in the NPRM. The potential consequence to aviation safety and the public interest of individuals with a recent history of DWI or DUI offenses piloting aircraft is at least as serious as for those driving motor vehicles, a situation demonstrated daily on our nation's highways. The agency believes that an individual whose conduct results in multiple alcohol- or drug-related motor vehicle actions within a 3-year period should be subject to enforcement action with the potential for removal from the flying environment.

Difference Between Piloting an Aircraft and Driving an Automobile

Numerous objections to the proposals in the NPRM assert that there is little or no relationship between the task of piloting an aircraft and driving an automobile. The commenters contend that training and the environment surrounding the operations of motor vehicles and aircraft are drastically different and should not be subject to similar regulations. The commenters state that pilots are carefully selected and subject to different medical requirements and training than those licensed solely to operate motor vehicles, and, therefore, cannot be so directly equated.

The FAA is well aware that there are differences in training for motor vehicle and aircraft operation. However, driving an automobile on our nation's roads requires some type of state medical examination, at a minimum an eye examination, as well as a statement of health from the applicant or driver. Commercial drivers usually undergo medical examinations while private automobile drivers usually must self-certify and take a vision test. Applicants must respond to questions concerning their prior driving records and medical status and must also demonstrate practical driving skills. These conditions have been an acceptable part of obtaining a driver's license for the vast majority of adult Americans who undergo this procedure regularly. Similar procedures are required for those choosing to pilot aircraft.

The FAA agrees with the commenters that a higher level of skill and care must be exercised by those piloting aircraft in the interest of the public. In comparison to driving, aviation-related errors in judgment can be more serious; there is potential for greater property damage; and a pilot, particularly when engaged

in commercial aviation, is responsible for the safety of passengers as well as for others both in the air and on the ground.

Legal Concerns

Numerous commenters raise issues that they believe are legal in nature. Three commenters argue that the proposed regulations overstep FAA's statutory authority, which involves the safety of flying. They believe that FAA regulations should address only the act of flying while under the influence of alcohol or drugs.

The FAA does not agree with these commenters. Information about a person's driving record, including DWI and DUI offenses, has long been required as a part of the application process for airman medical certification. Moreover, the FAA believes that conduct outside the time actually spent flying can be relevant to a determination of a person's capability to pilot an aircraft. Multiple driving convictions or administrative actions involving alcohol or drugs have relevance to the issues of judgment, compliance disposition, and medical qualifications.

Twenty-three commenters, including three organizations, oppose the NPRM on the basis of its intrusive nature. They argue repeatedly that since there is no statistical evidence to support the linking of a pilot's past driving record with his or her potential for alcohol or drug use in the cockpit, very little relevance exists for requiring access to the records in the NDR. As a result, it is argued that such a requirement by the FAA is, by nature, an invasion of privacy. Several commenters say that until definite proof is presented linking the two types of operation, no justification exists for the proposals.

The FAA acknowledges that there may be an impact on the privacy of individuals by virtue of obtaining the information in the NDR, but the impact is neither large nor unwarranted. First, most information in the NDR is public record information from the participating states. Second, the medical application already requires an applicant to reveal his or her driving record. Therefore, accessing the information in the NDR should not result in developing any new information about the applicant. Third, Congress passed legislation explicitly granting the FAA the authority to receive information contained in the NDR. The legislation contains limitations that safeguard the privacy interests of individuals whose NDR records are disclosed to the FAA.

Regarding the express consent form to be attached to the medical application for use in obtaining NDR information, one commenter states that the FAA's obtaining "express consent by a deliberate and knowing act of administrative extortion" is without statutory authority. This commenter believes that it is inappropriate to withhold issuance of a medical certificate if a person refuses to give consent to access the NDR.

The FAA does not agree. Indeed, the statute granting the FAA authority to receive NDR information tied the use of the information specifically to the medical certification process. The statute provides that that information is to be used "to verify information required to be reported to the Administrator by an airman applying for an airman medical certificate and to evaluate whether the airman meets the minimum standards as prescribed by the Administrator to be issued an airman medical certificate." [23 U.S.C. 401 note]

Numerous commenters said that pilots' constitutional rights would be violated because there is no opportunity for a hearing or appeal following "automatic" certificate action for two DWI convictions.

The FAA does not agree. This rule provides that multiple motor vehicle actions against a person within a 3-year period are grounds for suspension or revocation of any certificate or rating issued to that person under part 61. There is no "automatic certification action." Rather, the FAA will initiate appropriate enforcement action, and the FAA's formal enforcement procedures will be followed. An airman will be afforded all of the procedural safeguards that are available generally in FAA certificate action proceedings. These proceedings could include notice of proposed certificate action and, possibly, a hearing before an administrative law judge, an appeal to the National Transportation Safety Board and, finally, judicial review of the determination.

Three commenters, including two organizations, state that retroactive enforcement is unfair. They note that pilots would have exercised more caution against receiving a DWI or DUI conviction if they had known such convictions might affect their pilots' licenses.

The FAA recognizes this concern. Under the proposed rule, at least one motor vehicle action would have had to occur after the effective date of the final rule. However, possible loss of an airman certificate is not the reason a person should comply with state laws related to alcohol or drug use in

operation of a motor vehicle. These alcohol- and drug-related highway safety laws should be adhered to because they are the law. The failure to comply has serious adverse consequences. Alcohol- and drug-related traffic accidents result in the deaths of thousands of Americans every year. While other traffic offenses may result in accidents, alcohol and drug impairment clearly pose the greatest threat and are the result of conscious decisions. Motor vehicle actions reflect a lack of safety awareness, a lack of good judgment, and an indifference to the adherence to established requirements of law. Nevertheless, the FAA recognizes that directly linking an individual's compliance disposition toward critical safety requirements in the driving context to possible certificate action against that individual's pilot certificate is a fundamental change. The FAA agrees that the correlation should be prospective and has so provided in this final rule. To the extent that the rule has a deterrent effect, resulting in a proper compliance attitude toward the FAR, the rule will have achieved its goal.

Ten commenters, including three organizations, suggest that, in the words of one individual, the "rule is using a flawed base for its determinations" because DWI or DUI convictions are based on substantially different state laws. These differences include varying permissible blood alcohol concentrations (BAC) and differing state procedures for those charged with DWI or DUI offenses. Therefore, these commenters argue that the proposed rule could not be applied equally to all airmen.

The FAA is aware of impairment level and procedural differences among the states. However, these differences in state laws and procedures, which are a part of our Federal system, are not a reason for inaction. Every person driving an automobile is required to obey the laws of the state in which the vehicle is being operated. The fact that state laws differ is not a defense to charges of violating a law, nor do state law differences undermine a rule that uses convictions or state administrative actions under those varying laws. In the NPRM, the FAA requested specific comments on whether to treat state judicial proceedings involving "probation before judgment" and "deferred adjudication" as a "motor vehicle action," even though these proceedings may not result in a permanent record of conviction. The FAA agrees with a commenter who recommends that procedures such as probation before judgment and deferred

adjudication not be considered motor vehicle actions. Further evaluation is needed of the possible impact on state procedures of including judicial proceedings that do not result in a conviction as a motor vehicle action under the rule. As defined in the rule, a motor vehicle action is a conviction; license cancellation, suspension, or revocation; or the denial of an application for a license to operate a motor vehicle by a state for a cause related to the operation of a motor vehicle while intoxicated by alcohol or a drug, while impaired by alcohol or a drug, or while under the influence of alcohol or a drug.

Finally, two commenters, including one organization, note that the Federal Highway Administration (FHWA) regulations refer only to "on duty" alcohol- and drug-related motor vehicle actions. The FHWA rule initially was broader, and included off-duty convictions for operating a vehicle under the influence of alcohol. These commenters refer to a judicial decision involving the initial rule, *Whalen v. Volpe*, 348 F. Supp. 1235 (D. Minn. 1972), in which the court concluded that the FHWA rule was arbitrary, capricious, and unreasonable. The court found an absence of any rational basis to conclude that there was a correlation between a conviction for drunken driving while in a private automobile and future conduct driving a commercial vehicle. The decision was vacated later based on a stipulation and agreement entered into by the Parties. *Whalen v. Volpe*, 379 F. Supp. 1143 (D. Minn. 1973), and FHWA engaged in further rulemaking. These commenters do not believe that the FAA reasonably can proceed to a final rule in light of the *Whalen* case.

The FAA is not persuaded that the *Whalen* case precludes promulgating a final rule in this rulemaking. Since the decision was vacated it has no precedential value. Moreover, there are significant distinctions between the FHWA rule and that agency's statutory authority and the FAA's rule and its statutory authority. The FAA believes that the *Whalen* rationale is no longer persuasive and that there have been significant changes in the recognition of the dangers of driving while impaired by drugs or alcohol and the reasonable inferences that can be drawn from such conduct about a person's judgment and compliance disposition. The effects of substance abuse on the safety of transportation are clear and the courts have recognized the authority of government agencies to take action to prevent these effects. Therefore, the

FAA is not persuaded that a court today would reach the same conclusion that was reached by the court in the *Whalen* case.

Self-Policing

Eighteen commenters, including two organizations, believe that only a small segment of the flying population abuses drugs or alcohol. The commenters argue that the overwhelming majority of the pilot population is already doing an excellent job of self-policing; thus this rule is unnecessary.

The FAA agrees that the majority of the pilot community complies with the regulations by self-policing. The FAA accepts, and has so stated, that only a small percentage of the airman population may be affected by abuse of alcohol or drugs. However, a single impaired or intoxicated pilot could cause extensive and wide-spread damage to the public through loss of life or property damage. The FAA believes that this regulation will encourage greater self-policing and intends it to be primarily corrective in nature, assisting the agency, through deterrence, in attaining its primary mission, that of aviation safety.

Enforcement

Nineteen commenters say that they believe the FAA has become irrationally harsh in its enforcement policy, not improving compliance, and damaging FAA's credibility. They state that this rule is one more step in this onerous direction.

The FAA's compliance and enforcement programs have been modified recently. The opinions of the flying population, particularly general aviation pilots, have been taken into consideration in the agency's on-going effort to maintain a high level of safety. There will be continued insistence on total compliance with the rules and regulations that have made our aviation system as safe as it is. But agency responsibility to enforce the rules will not prevent the FAA from addressing the aviation community's concerns and enhancing the FAA's responsiveness to the users of the system. The goal is to be firm but fair. The FAA intends to use a number of tools, including good communications, training, education, counseling, and finally enforcement, to achieve the primary goal of safety.

The FAA has become aware that there is a good deal of misunderstanding about the enforcement process, leading to a sense of mistrust. Therefore, the new enforcement procedures will be more flexible, with greater emphasis on promoting compliance through education and open communication. The

FAA will consider the need for simplification in some of the regulations to enhance understanding and promote compliance.

Nevertheless, clear-cut violations of regulations and a lack of compliance disposition must be handled decisively in the interest of promoting safety, particularly in such safety-sensitive areas as alcohol and drug abuse. The FAA regards violations in these areas as serious and will continue to expect strict adherence to the regulations. As stated in a recent FAA notice of enforcement policy (54 FR 15144; April 14, 1989), failure to disclose DWI or DUI convictions when applying for an airman medical certificate may be a violation of § 67.20 of the FAR. In pertinent part, that section provides that no person may make or cause to be made any fraudulent or intentionally false statement on any application for an airman medical certificate; so doing is a basis for suspending or revoking any airman certificate or rating held by that person.

Persons who make false statements on an application for an airman medical certificate also may be criminally prosecuted under 18 U.S.C. 1001, which carries a fine of not more than \$10,000 or a term of imprisonment for up to 5 years, or both. While the FAA refers cases for consideration, the Department of Justice determines whether to prosecute a person under this statute.

Punishment

Twenty-one individuals and two organizations provided comment on the allegedly punitive nature of this rule. Seven commenters and one organization believe that the regulation should be more stringent, to include such issues as suspension of a pilot's license for a single DWI conviction.

The FAA considered basing enforcement on a single drug- or alcohol-related motor vehicle action, but chose not to do so because there are existing procedures that call for the review of any medical application in which the applicant discloses a past motor vehicle action. This review could lead to further action resulting in the denial, suspension, or revocation of a medical certificate. This review takes place at the time of the initial submission of a medical application, and is performed by the Aviation Medical Examiner (AME), followed by an additional agency review. Regarding the falsification issue, there is an existing FAR (§ 67.20) governing the providing of accurate information to the FAA, and Federal legislation exists (18 U.S.C. 1001) to address the criminal aspect of providing false information.

On the other hand, 13 commenters objected to the NPRM, making the argument that the "punishment" resulting from this rule is harsh and excessive. An airman certificate is required of all pilots; in the case of professional pilots, suspension or revocation would deprive them of their livelihood. This treatment, according to the arguments of the commenters, is too severe in comparison to other industries.

The FAA agrees that certificate suspension or revocation is a severe action, but one that fits the seriousness of the violation involved. The intent of these regulations is primarily corrective in nature, and to achieve the FAA's mandate to ensure safety in aviation. Therefore, the FAA will take appropriate enforcement action where pilots have violated laws related to substance use or abuse while operating a motor vehicle.

One organization states that virtually every pilot subject to an alcohol- or drug-related motor vehicle action will challenge any prosecution to the fullest extent of the law. While the FAA has no reason to doubt the comment's assertion, there are ample reasons to contest a DWI or DUI charge apart from the action being taken in this rule. The decision to challenge a criminal or administrative charge is an option available to any individual in our society. If a pilot's record is reviewed pursuant to § 61.15 for possible denial of an application for a certificate or a rating, or suspension or revocation of an existing airman certificate or a rating, it is because the pilot has violated an FAA regulation. The opportunity for due process, as always, is available both in a state's criminal and administrative proceedings and the FAA's administrative proceedings.

Medical Examination Form

As adopted, this rule amends § 61.15 to require a pilot to report to the agency's Civil Aviation Security Division in Oklahoma City each alcohol- or drug-related motor vehicle conviction or administrative action that occurs after the effective date of the rule. This reporting requirement is unrelated to the existing requirement that a pilot fully and completely answer all questions related to traffic and other convictions on an "Application for an Airman Medical Certificate or Airman Medical and Student Pilot Certificate", FAA Form 8500-8. One commenter contends that this requirement to describe any previous record of convictions should not be necessary as he is " * * * at a loss to see the relevance between an

airman making an illegal U-turn and his/her medical history."

The FAA considers an airman's conviction history pertinent to the medical certification process. An Aviation Medical Examiner (AME) uses this information, combined with the physical examination findings, as an important diagnostic tool. A history of traffic or other convictions may indicate a medical problem or may lead to further inquiry regarding an applicant's medical qualifications. While an illegal U-turn conviction, in and of itself, may not alert an AME to a possible medical problem, multiple traffic convictions might. Any reportable conviction information, coupled with a DWI or DUI conviction, could raise a question as to the applicant's fitness to perform the duties or exercise the privileges of an airman certificate. Given all the information, an AME and the agency can more accurately assess a pattern of behavior that may be indicative of a personality disorder that has repeatedly manifested itself by overt acts and, thus, may warrant denial of an application for, or suspension or revocation of, an airman's medical certificate.

Another commenter states that nowhere on the FAA Form 8500-8 does the seriousness of failing to disclose convictions appear. The agency refers that commenter to the lower left-hand corner of the form which contains a notice describing penalties for falsification or failure to disclose the information required.

Still other commenters believe that the possibility of an applicant overlooking a question, or of making an error in his or her response, is compounded by placing the conviction information the FAA is seeking within a small area in the medical history section of the form.

Data released on February 17, 1987, based on an audit conducted over a 7-year period by the CIG, indicate that more than 98.5 percent of the pilot population with convictions to report have done so successfully using the current form. The FAA, however, recognizes the merit of the commenters' desire to improve FAA Form 8500-8 to achieve an even higher degree of compliance and clarity and, thus, to lessen the opportunity for error.

At this time, the FAA is revising the current form for consistency with the amendment to part 67 as adopted in this final rule. The express consent provision is added to the form and is placed above the space provided for the applicant's signature. This provision allows the FAA to receive information about the applicant that has been reported to the NDR.

Along with the addition of the express consent provision, the agency is taking the opportunity to incorporate those suggestions that it deems will enhance the appearance and clarity of the form. Changes, in part, include revising the instructions for filling out the form; increasing the type-size, where possible; moving the conviction items to a more prominent location within the medical history section; and updating the portion that deals with penalties for falsification. The agency believes that these revisions will enable more applicants for an airman medical certificate to provide the required information accurately and with less effort.

Rehabilitation and Education

Several commenters believe there should be provisions made for rehabilitation and education. According to the commenters, the time and effort which the FAA would spend with this program would be better spent in developing and encouraging rehabilitation programs. The FAA is described by the commenters as more concerned with taking punitive measures taken to remove the offending individuals from the aviation community than with taking a more humane, restorative approach of "compassionate intervention and rehabilitation."

The FAA accepts and endorses education and rehabilitation as important and necessary facets of any drug or alcohol program. In fact, the agency has an active and successful employee assistance program (EAP). The FAA encourages the creation and use of industry EAPs. The FAA also encourages individuals to seek help if they have a substance abuse problem. Community health organizations generally have programs to assist such individuals. However, the primary mission of the FAA is aviation safety and the identification of associated safety problems.

Paperwork Burden

Four commenters say that this regulation would cause an undue paperwork burden on the FAA.

There admittedly will be an increase in workload among the various offices responsible for implementation of this rule. However, the agency believes that the potential for increased safety in the aviation community justifies the additional burden. Every effort will be made, however, to reduce the burden of the agency's new recordkeeping requirements. For example, in revising the application for medical certification, FAA Form 8500-8, the NDR access express consent provision will be

printed on the form itself, thus eliminating an extra document that must be retained by the FAA. A detailed listing of the reporting and recordkeeping requirements can be found in Part IV of the Regulatory Evaluation which is contained in the docket.

Insufficient Reporting Time

Several respondents note that pilots should be given more than 60 days to report past alcohol- or drug-related driving convictions and administrative actions. They contend that 60 days from the effective date of the final rule does not allow sufficient time for a pilot to learn of the promulgation of the regulation and then to report past motor vehicle actions. One organization suggests pilots might find it necessary to contact state officials, determine the nature of certain prior state actions, and then seek counsel on whether reporting of a specific action is required under the regulations.

Although the NPRM proposed the reporting of each alcohol- or drug-related motor vehicle action received in the 3-year period prior to the rule, this provision is not being adopted. The final rule requires only reporting of alcohol- and drug-related motor vehicle convictions or state administrative actions received after the effective date of the rule. The notification of each motor vehicle action must be received by the agency within 60 days after the conviction or administrative action. Given the deletion of the requirement to report motor vehicle actions that occurred in the 3-year period prior to the effective date of the final rule, the FAA believes that the 60-day notification period is realistic and reasonable. In addition, the effective date of the final rule is 120 days after publication in the Federal Register. This fairly lengthy period should provide ample opportunity for the final rule requirements to be made widely known.

Proposed Amendment to § 61.23, Duration of Medical Certificates

The NPRM proposed amending § 61.23 by adding new paragraph (d) to change the duration of an airman medical certificate. The proposed amendment provided that any medical certificate would expire automatically on the 61st day after a pilot was convicted of, or a state had taken administrative action on, a single alcohol- or drug-related motor vehicle violation; unless the medical certificate would otherwise expire before the 61st day. The pilot could continue to operate an aircraft for 60 days after the date of conviction or

until expiration of the certificate, if earlier, as long as the pilot was not otherwise disqualified under part 67. The pilot could schedule and complete a new medical examination anytime after the date of the motor vehicle action. If the pilot chose to reapply within 60 days after the conviction, and, if based on this examination and the agency's review of the conviction or administrative action, the pilot continued to meet the medical standards of part 67, then he or she would be issued a new medical certificate and could continue to pilot an aircraft without interruption.

In addition, the NPRM proposed in new paragraph (d)(1) that each applicant be required to present to the AME, at the time of application and medical examination for a new certificate, any documents that substantiated participation in any court-ordered substance abuse treatment plan, and in new paragraph (d)(2), that each subject applicant be required to show the AME evidence of compliance with any other court-ordered program related to the conviction, such as community service.

Numerous commenters contend that no measure should be taken to deny an application for, or suspend or revoke, an airman's medical certificate for a single DWI or DUI conviction or action but, rather, the airman should continue to be required to report convictions on the medical application form as a basis for further medical evaluation. The commenters support the FAA's efforts to deny medical certification to airmen with disqualifying alcohol- or drug-related medical conditions, but argue that a medical diagnosis seems unlikely based solely on a single alcohol- or drug-related motor vehicle conviction or state administrative action. Still others question the premise that, based on a single DWI or DUI action, the agency would discover pilots with alcohol or drug problems. These commenters believe that if the agency considered this proposition likely, the proposed amendment to § 61.23 would not have been drafted to allow such individuals the latitude to continue to pilot an aircraft for up to 60 days without having to undergo a medical evaluation.

Some commenters have taken the FAA to task over the requirement in the proposed rule to have the AME evaluate court and other administrative records, presented by the examinee, to determine compliance with any court-ordered program related to a conviction. These court-imposed programs could vary from attendance in a substance-abuse treatment program to participation in a community service program. Other

commenters, themselves physicians, also express grave reservations over this issue. They believe that the AME would be placed in the unfamiliar role of reviewer and verifier of legal documents, and would further have to attempt to determine if the sanctions imposed had been, or were being, discharged accordingly.

The FAA has considered the commenter's views regarding the likelihood of obtaining significant results from requiring a pilot to reapply for a medical certificate after a single motor vehicle action (DWI, DUI, or state administrative action). The agency agrees that only rarely would a medical examination triggered as a result of a single motor vehicle action provide a basis for a diagnosis of alcoholism or drug dependency. The additional examinations that would have been triggered by the proposed requirement would be a significant increase in workload to the agency and an expenditure of community medical resources; conservatively, the FAA estimates that 7,000 additional applications for medical certification would be processed annually. Also of consequences would be the fees to be paid by the airmen in compliance with the reexamination requirement. If the findings from the additional examinations prove minimal, as expected, then imposing these requirements appears to be unwarranted.

The FAA has further determined that the provisions as proposed in § 61.23(d)(2) are beyond the scope of current AMEs' training or expertise. It is FAA policy that every DWI or DUI conviction or state motor vehicle administrative action noted on an application for an airman medical certificate be reviewed by the Aeromedical Certification Division of the Civil Aeromedical Institute (CAMI) for indications of a condition warranting denial of an application or suspension or revocation of a medical certificate. This includes an additional medical review when multiple motor vehicle actions are listed on an application for a medical certificate. Two motor vehicle actions within 3 years, as provided by new § 61.15(d), still will provide grounds for certificate action against a pilot's airman certificate apart from any additional medical review. Thus, after considering all the comments received, the FAA has not adopted in this final rule the proposed amendment to § 61.23.

Pursuant to new § 61.15, the agency requires that a pilot report each alcohol- or drug-related motor vehicle conviction or administrative action that occurs

after the effective date of the rule to the Civil Aviation Security Division (CASD) in Oklahoma City. The report of a motor vehicle action will result in a review of that pilot's medical file to determine if there is a basis for reconsideration of the individual's eligibility for medical certification.

The FAA is confident that the early identification mechanisms currently in place, the new reporting requirement, and the scheduled crosscheck of the airman medical records with the NDR, are sufficient to maintain the requisite high level of safety for the aviation community and the traveling public. Thus, the FAA has concluded that limiting the duration of a medical certificate after a single motor vehicle action is not warranted.

Costs

Four commenters, including one organization, raise economic issues. Three say that the administrative paperwork would not be "nominal," and that the FAA should attempt to quantify these costs. The FAA agrees, and has specified the step-by-step process, with the costs involved in each step, in Section IV of the Regulatory Evaluation.

Two of the commenters say that the loss of pilot employment or pay resulting from this rule should be considered as a cost of this rule. The FAA disagrees because this rule merely identifies those pilots already having received alcohol- or drug-related motor vehicle convictions or administrative actions. Any cost is related to these pilots' own actions rather than the FAA's actions.

One commenter notes that the FAA stated in the NPRM that the loss of employment is not a regulatory cost and "that the proposed rules would not have a significant economic impact . . . on a substantial number of small entities." This commenter asked whether a pilot is considered a small entity. The quoted language is based on the Regulatory Flexibility Act of 1980 (RFA) and comes from the Regulatory Flexibility Determination section of the NPRM. The FAA is required to ensure that small entities are not unnecessarily and disproportionately burdened by Government regulations. The criteria for a "substantial number of small entities" is one-third of the small firms subject to the final rule, but no fewer than 11 firms. This commenter understood "small entity" to mean an individual pilot, instead of a small firm. A firm, regardless of size, is made up of employees. In this case, the small firm being referenced here is made up of pilots and other employees. The loss of employment for an individual pilot may

or may not have a "significant economic impact" on a substantial number of small entities." In this case, the FAA has determined that this rule would not have such an impact.

Section-By-Section Discussion of the Rules

Several changes from the NPRM language have been made in the final rule. Some differences are intended to improve clarity; others are of a more substantive nature.

Section 61.15 Offenses Involving Alcohol or Drugs

Section 61.15(c) of the final rule has been modified to reflect that only motor vehicle actions that occur after the effective date of the rule must be reported to the FAA. The proposed rule had referenced reporting responsibility in the pilot's recent past as well as after the effective date. Reporting alcohol- or drug-related convictions or state motor vehicle administrative actions in the recent past is not a requirement of the final rule. This change is also reflected in paragraphs (d) and (e).

A modification was made to § 61.15(d) of the final rule to reflect that multiple motor vehicle actions as defined in the rule resulting from the same driving incident or factual circumstances will be viewed as one motor vehicle action for purposes of § 61.15(d). However, a pilot will must report each action to the FAA, regardless of whether it arises out of the same driving incident or factual circumstance. As part of the pilot's description of the action, the pilot should note that the action being reported is part of a single set of factual circumstances and reference any prior action arising out of the same facts.

Section 61.15(e) of the final rule differs from the proposed rule in the address to which the information must be sent. This has been changed from the Airman Certification Branch to the Civil Aviation Security Division.

Section 61.15(f)(1) of the final rule differs from the proposed rule (§ 61.15(e)(1)) in one minor respect. The final rule provides that the denial of any application for a certificate for a 1-year period dates from "the date of the last motor vehicle action" as compared to the proposed rule language which states "the date of the failure to report a motor vehicle action."

Section 61.23 Duration of Medical Certificates

The NPRM proposed amending § 61.23 by adding a new paragraph (d) to change the duration of an airman's medical certificate. This requirement has not been adopted in the final rule.

Section 67.3 Access to the National Driver Register

Two minor changes were made to this section. First, the rule has been changed to clarify that a person desiring to review the NDR information must request that the Administrator make the information available. Second, additional language has been added to clarify that the consent authorizes the Administrator to request the chief driver licensing official of the state to transmit information contained in the NDR about the person to the Administrator.

Finally, certain editorial changes in the final rule have been made for clarity.

Paperwork Reduction Act

Section 61.15(d) would require a pilot to report to the FAA each alcohol- or drug-related motor vehicle conviction and each alcohol- or drug-related state administrative action. Information collection requirements in the amendment to § 61.15(d) have been submitted for approval to the Office of Management and Budget (OMB) under the provisions of the Paperwork Reduction Act of 1980 (Pub. L. 96-511).

Regulatory Evaluation Summary

Executive Order 12291, dated February 17, 1981, directs Federal agencies to promulgate new regulations or modify existing regulations only if the potential benefits to society for the regulatory changes outweigh the potential costs to society. The order also requires the preparation of a Regulatory Impact Analysis of all "major" rules except those responding to emergency situations or other narrowly-defined exigencies. A "major" rule is one that is likely to result in an annual effect on the economy of \$100 million or more, a major increase in consumer costs, or a significant adverse effect on competition.

This final rule is determined not to be "major" as defined in the Executive Order, therefore a full Regulatory Impact Analysis evaluating alternative approaches is not required. A more concise Regulatory Evaluation has been prepared, however, which includes an analysis of the economic consequences of the regulation. This analysis has been included in the docket, and quantifies, to the extent practical, estimated costs as well as the anticipated benefits, and impacts.

A summary of the Regulatory Evaluation is contained in this section. For a more detailed analysis, the reader is referred to the full Evaluation contained in the docket.

The final rule establishes a basis for the denial of an application for a pilot

certificate and a basis for the revocation or suspension of a pilot certificate for pilots convicted of alcohol- or drug-related motor vehicle offenses or for pilots penalized as a result of state administrative action for cause. Under this final rule, a pilot must report to the FAA any conviction or administrative action that occurs after the effective date of the rule. Failure to report even one conviction or administrative action to the FAA is grounds for denial of an application for an airman certificate and grounds for suspension or revocation of a certificate issued under part 61. This reporting requirement is distinct from the existing requirement to report traffic and other convictions on an application for an airman medical certificate.

The FAA's denial of an application and the suspension or revocation of an existing certificate will be based on two or more alcohol- or drug-related motor vehicle convictions, two or more administrative actions by a state for cause, or at least one conviction and one administrative action occurring within a 3-year period.

This final rule amends § 61.15 of the Federal Aviation Regulations (FAR) and affects an estimated 752,000 individuals currently holding active medical certificates in conjunction with student, private, commercial, airline transport, glider-only, and lighter-than-air pilot certificates and ratings issued by the FAA. Promulgation of this final rule could result in the denial, revocation, or suspension of the privilege to operate an aircraft for an estimated 1,000 to 12,000 pilots annually. The costs of suspension or revocation of a certificate issued under part 61 will be the negative economic impact associated with the temporary or permanent loss of employment for pilots engaged in commercial aviation. The FAA does not consider this a cost of the rule; rather it considers these costs to be the result of alcohol or drug use in connection with the operation of a motor vehicle.

The FAA has calculated the present value cost of this rule to be \$4,409,794, discounted over a 10-year period, in 1990 dollars. The vast bulk of these costs are internal FAA administrative costs and will not be borne by the individual pilots. The costs occurring in the first year are estimated to be \$1,116,604, in the second year are estimated to be \$870,785, and in each subsequent year are estimated to be \$644,158.

The FAA has incorporated a consent provision in the FAA medical application form (Form 8500-6, the "Application for Airman Medical Certificate or the Airman Medical and Student Pilot Certificate") for use in

searching for alcohol- or drug-related convictions or administrative actions reported to the National Driver Register (NDR). This consent will allow the FAA to query the NDR about every pilot who applies for an airman medical certificate.

Based on the requirements of the final rule, airman will have 60 days to send a letter to the Civil Aviation Security Division (AAC-700) with their name, airman certificate number, and information about any DWI or DUI conviction or state administrative action acquired after the effective date of the rule.

Depending on the certificate held or the operations conducted, each pilot must have a physical examination every 6 months, 1 year, or 2 years; at that time, the following screening/checking process will begin for that pilot. An average of 10,000 pilots per week undergo FAA physicals. Thus, the FAA facility in Oklahoma City processes the 10,000 applications for medical certification per week. A tape with the pilot data will be sent each week, through the appropriate agencies, to the NDR. The NDR will match this tape against its register, and will create a tape of any pilot data entries that agree. This information will then be returned to the FAA, and will be used to obtain the necessary state driving records. The resulting data on the estimated 200 pilots per week will be compiled for comparison with medical history data and with the disclosures required for § 61.15.

The FAA expects that this rule will reduce the number of aviation accidents caused by pilots who may be impaired by alcohol or drugs during aircraft operations. However, the FAA has been unable to directly quantify the expected benefits of the final rule. Some observations can be made, however, regarding potential benefits. During the period from 1978 to 1987, 6.0 percent of general aviation pilots killed in aviation accidents had a blood alcohol level of at least 0.04 percent. During this same 10-year period, 11,213 people died in general aviation accidents. If 6.0 percent of these people died in accidents where the pilot was under the influence or impaired by alcohol, over 670 people died in accidents where alcohol may have been a contributing cause.

Based on this analysis, and using \$4.4 million as the present value 10-year cost of the rule, the chart below shows the cost of saving one life as a function of the effectiveness of the rule in preventing accidents.

Effectiveness of rule (percent)	Cost of rule per life saved (dollars)
1.....	\$640,000
10.....	\$64,000
20.....	32,000
30.....	21,300
40.....	16,000
50.....	12,800
60.....	10,700
70.....	9,100
80.....	8,000
90.....	7,100
100.....	6,400

At this time, the FAA cannot accurately predict how effective the rule will be in preventing fatalities such as discussed above. Even if it proves to be only 1 percent effective, however, the cost per fatality prevented appears to be less than values currently ascribed to a statistical life. The FAA believes that the rule will be more effective than 1 percent and concludes that the potential benefits of the rule will exceed potential costs.

Four commenters raise economic issues based on the cost/benefit analysis in the Notice of Proposed Rulemaking (NPRM). A discussion of these comments is contained in the final Regulatory Evaluation contained in the docket and elsewhere in the preamble to the rule.

Regulatory Flexibility Determination

The Regulatory Flexibility Act of 1980 (RFA) was enacted by Congress to ensure that small entities are not unnecessarily and disproportionately burdened by Government regulations. The RFA requires Federal agencies to review rules which may have a "significant economic impact on a substantial number of small entities."

The FAA's criterion for a "substantial number" are a number which is not less than 11 and which is more than one-third of the small entities subject to the rule. For air carriers, a small entity has been defined as one who owns, but does not necessarily operate, 9 or less aircraft. The FAA's criterion for a "significant impact" are at least \$3,800 per year for an unscheduled carrier, \$53,500 for a scheduled carrier having an airplane or airplanes with only 60 or fewer seats, and \$95,800 per year for a scheduled carrier having an airplane with 61 or more seats.

The FAA has determined that the rule will not have a significant economic impact, positive or negative, on a substantial number of small entities. The basis of this determination is the FAA's opinion that any adverse economic consequences associated with the loss of the privilege to operate an aircraft for

aviation pilots convicted of alcohol- or drug-related motor vehicle offenses or penalized as a result of State administrative action for cause is the direct consequence of alcohol or drug use in connection with the operation of a motor vehicle and not as a result of the rule. Since there are minimal economic consequences due to the rule, the total costs that could be attributable to a significant number of small entities are below the threshold dollar limits.

Trade Impact Statement

This final rule will affect only those individuals who hold an FAA-issued airman certificate and, therefore, would have no impact on trade opportunities for U.S. firms doing business overseas or foreign firms doing business in the United States.

Federalism Implications

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this regulation would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Conclusion

For the reasons discussed in the preamble, and based on the findings in the Regulatory Flexibility Determination and the International Trade Impact Analysis, the FAA has determined that this regulation is not a major regulation under the criteria of Executive Order 12291. In addition, the FAA certifies that this regulation will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. This regulation is considered significant under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979). A regulatory evaluation of the regulation, including a Regulatory Flexibility Determination and International Trade Impact Analysis, has been placed in the docket. A copy may be obtained by contacting the person identified under "FOR FURTHER INFORMATION CONTACT."

List of Subjects

14 CFR Part 61

Aircraft, Airmen, Alcoholism, Aviation safety, Drug abuse, Recreation and recreation areas, Reporting and recordkeeping requirements.

14 CFR Part 67

Airmen, Aviation safety, Health, Reporting and recordkeeping requirements.

The Amendments

In consideration of the foregoing, the Federal Aviation Administration amends part 61 and part 67 of the Federal Aviation Regulations (14 CFR parts 61 and 67) as follows:

PART 61—CERTIFICATION: PILOTS AND FLIGHT INSTRUCTORS

1. The authority citation for part 61 is revised to read as follows:

Authority: 49 U.S.C. App. 1354(a), 1355, 1421, 1422, and 1427; 49 U.S.C. 106(g) (Revised Pub. L. 97-449, January 12, 1983).

2. By amending § 61.15 by adding new paragraphs (c), (d), (e), and (f) to read as follows:

§ 61.15 Offenses involving alcohol or drugs.

(c) For the purposes of paragraphs (d) and (e) of this section, a motor vehicle action means—

(1) A conviction after November 29, 1990, for the violation of any Federal or state statute relating to the operation of a motor vehicle while intoxicated by alcohol or a drug, while impaired by alcohol or a drug, or while under the influence of alcohol or a drug;

(2) The cancellation, suspension, or revocation of a license to operate a motor vehicle by a state after November 29, 1990, for a cause related to the operation of a motor vehicle while intoxicated by alcohol or a drug, while impaired by alcohol or a drug, or while

under the influence of alcohol or a drug; or

(3) The denial after November 29, 1990, of an application for a license to operate a motor vehicle by a state for a cause related to the operation of a motor vehicle while intoxicated by alcohol or a drug, while impaired by alcohol or a drug, or while under the influence of alcohol or a drug.

(d) Except in the case of a motor vehicle action that results from the same incident or arises out of the same factual circumstances, a motor vehicle action occurring within 3 years of a previous motor vehicle action is grounds for—

(1) Denial of an application for any certificate or rating issued under this part for a period of up to 1 year after the date of the last motor vehicle action; or

(2) Suspension or revocation of any certificate or rating issued under this part.

(e) Each person holding a certificate issued under this part shall provide a written report of each motor vehicle action to the FAA, Civil Aviation Security Division (AAC-700), P.O. Box 25810, Oklahoma City, OK 73125, not later than 60 days after the motor vehicle action. The report must include—

(1) The person's name, address, date of birth, and airman certificate number;

(2) The type of violation that resulted in the conviction or the administrative action;

(3) The date of the conviction or administrative action;

(4) The state that holds the record of conviction or administrative action; and

(5) A statement of whether the motor vehicle action resulted from the same incident or arose out of the same factual

circumstances related to a previously-reported motor vehicle action.

(f) Failure to comply with paragraph (e) of this section is grounds for—

(1) Denial of an application for any certificate or rating issued under this part for a period of up to 1 year after the date of the motor vehicle action; or

(2) Suspension or revocation of any certificate or rating issued under this part.

PART 67—MEDICAL STANDARDS AND CERTIFICATION

3. The authority citation for part 67 is revised to read as follows:

Authority: 49 U.S.C. App. 1354(a), 1355, 1421, and 1427; 49 U.S.C. 106(g) (Revised Pub. L. 97-449, January 12, 1983).

4. By adding new § 67.3 to read as follows:

§ 67.3 Access to the National Driver Register.

At the time of application for a certificate issued under this part, each person who applies for a medical certificate shall execute an express consent form authorizing the Administrator to request the chief driver licensing official of any state designated by the Administrator to transmit information contained in the National Driver Register about the person to the Administrator. The Administrator shall make information received from the National Driver Register, if any, available on request to the person for review and written comment.

Issued in Washington, DC, on July 28, 1990.

James B. Busey,

Administrator.

[FR Doc. 90-17827 Filed 7-26-90; 4:37 pm]

BILLING CODE 4910-12-M

Mr. Chairman and Members of the Subcommittee,

I appreciate the opportunity to provide testimony concerning “The FAA’s Oversight of Falsified Airman Medical Certificate Applications”.

I would like to begin by stating that undoubtedly any testimony you’ve already heard from high ranking employees of the Federal Aviation Administration (FAA) or the Department of Transportation Office of the Inspector General (DOT/OIG) on this topic, will be decidedly different from my experience. I am providing this information because I feel it is terribly important for this subcommittee to understand why I believe the FAA has rendered itself totally incapable of providing effective action against the criminal element whose sole intent is to defraud the agency through the Falsification of Airman Medical Certificate Applications, as well as any and all other criminal acts. I will attempt to explain as succinctly as possible the historical events that created, what I and many others feel, is an utterly deplorable situation, and will support all of my comments with pertinent laws, rules and regulations, many of which the agency is simply ignoring.

As a way of introduction let me say that I retired from the FAA in October 2006 after a distinguished career in the Security and Hazardous Materials Division. At the time of my retirement, and for the five years prior, I faithfully served as Division Manager of the Northwest Mountain Regional Office of Security in Seattle, Washington.

The FAA is, at its foundation, a regulatory agency; in addition, following inception of the FAA Act of 1958, it was also mandated with a criminal investigative responsibility for the violation of Federal Aviation Regulations that would serve to degrade aviation safety and safety of the flying public.¹ Those specific responsibilities mandate that the FAA investigate such crimes. The standard operating procedure requires that the FAA Airman Medical Division and/or Flight Standards Division, having received notification of possible falsification of the documents of concern, are required to refer such information to the Security and Hazardous Materials Division for investigation. FAA Orders and Directives, derived from public law, require that FAA Security Special Agents aggressively investigate and determine criminal intent of such falsification. If criminal intent is uncovered the agents are expected to seek prosecutorial remedies through the United States Attorneys Office. However, a critical problem with this process was created in March 2001, when the FAA Administrator (Garvey) and Secretary of Transportation (Slater) violated federal law by authorizing the *transfer* of criminal investigative responsibilities associated with, not only the records being addressed today, but all other acts of criminal malfeasance that would serve to degrade aviation safety.² In essence, the Administrator

¹ **Title 49 United States Code, Section 106(g).** . . ., the Administrator shall carry out – (A) duties and powers of the Secretary of Transportation Under subsection (f) and stated in section . . . 46306–46308, 46310–46311 & 46313–46316 (specific criminal statutes from the Criminal Code book concerning aviation safety)

² **Title 49 United States Code, Section 106(h):** This title applies to duties and powers specified in subsection (g)(1) of this section. Any of those duties and powers may be transferred to another part of the Department only when specifically provided by law or a reorganization plan submitted (to Congress) under chapter 9 of Title 5 (Amendment of the IG Act)

has completely severed the agencies investigative arm and no longer has a unit which can be guided and directed into any such investigation.³

The impact of losing this investigative arm is that currently, when falsification of Airman Medical Certificate Applications occurs, the Security Division can no longer perform its mandated responsibility, but is now required to refer all such cases to the DOT/OIG. There are problems associated with this situation. Although the FAA continues to retain a portion of its former investigators and identify them as *Special Agents*, the truth is these well trained and experienced individuals have been completely stripped of all criminal investigative authority that would allow for the aggressive efforts necessary (as per Law, Rule and Regulation) to fight forces intending to degrade aviation safety.

I am sure in the testimony from the FAA and/or the DOT/OIG you will hear that the FAA did not, nor does it currently, have the resources available to provide for this responsibility. This is simply not true. As in any government agency resources are currently stretched and I can not speak to the regulatory side of the FAA. However, at one time, I had six full time special agents working in the Northwest Mountain Region fully capable of handling the numerous criminal and regulatory investigations that were requested and proactively found in our area of responsibility. In addition, our Alaska Region had 4 full time agents, a state where the per capita ownership of aircraft is higher than all others. Currently, the Northwest Mountain Region has 3 full time agents, one with nearly 10 years of law enforcement experience, another with four and a manager with nearly 16 years, all of which is going to waste. The Alaska Region (now part of Northwest Mountain) currently has no full time agents, but does have a manager with 10 years of law enforcement. The resources are still available, just not utilized.

Additionally, please consider that the DOT/OIG was created as an office to provide oversight (the OIG priority) to insure the FAA follows its mandate of investigating the violation of FAA Regulations.⁴ The fact is, the DOT/OIG has never been assigned statutory authority for aviation safety based on the non-compliance with Federal Aviation Regulations.⁵ There is good reason for this limitation of authority. After all, who holds the DOT/OIG accountable if they fail to investigate air safety concerns based on the violation of FAA Regulations? No-one.

At the time of my retirement, and since the transfer of responsibility to the DOT/OIG, my office forwarded approximately 80 potential criminal violations of FAA Regulations to the DOT/OIG. At the time of my retirement only around 20 of those referrals were actively investigated, while the remainder simply received no attention whatsoever. That figure represents only one FAA

³ **Section 902 FAA Act of 1958:** Provides criminal sanctions for a series of acts or activities related to aviation safety. Section 902 (O) provides that Sections 902(i) – (n) shall be investigated by the FBI (i.e. hijacking) and the remaining violations are the responsibility of the FAA (i.e. certification of airman, aircraft). * This clearly shows evidence of delineation of authority between different agencies.

⁴ **IG Act of 1978 9(a)** There shall be transferred – (2) such other offices or agencies . . . except that there shall not be transferred to an IG under paragraph (2) PROGRAM OPERATING RESPONSIBILITIES (** i.e. such as those based on civil/regulatory statutes – like falsifying FAA medical applications)

⁵ **FAA Order 2150.3A Section 308** The Inspector General Act of 1978 (5 USC Appendix 1) established the Office of the Inspector General in the Department of Transportation, as an independent and objective unit to conduct and supervise audits and investigations relating to programs and operations of the Department. (2)(b) The Inspector General **does not have** any responsibility or authority for enforcing compliance with aviation safety regulations under the jurisdiction of the FAA. (This Order is still in existence but is being blatantly ignored)

Security Region, of which there are eight nationwide. I believe these sad numbers serve to clearly illuminate the fact that falsification of airman medical certificate applications, and all other acts of malfeasance, are no-longer being properly addressed. Even more appalling, is that in my capacity as Division manager, when I would report this information to my superiors in Washington, it was just ignored.

The final consideration I would like the subcommittee to understand is that taxpayer money is still being utilized to pay the FAA special agents, even though their responsibilities have been almost completely eliminated. The taxpayer still pays, yet aviation safety issues are not being aggressively addressed! This handcuffing of the FAA investigators remains in place, even though upper management is fully aware the DOT/OIG has demonstrated sporadic interest in aviation safety matters, not to mention the fact that the DOT/OIG cannot be held accountable.

In the testimony from the DOT, I am sure you will hear about "Operation Safe Pilot". While this operation is a good program, it simply misses the mark. It involved the wrong agencies. The Social Security Administration (SSA) OIG had a vital role, but what is the DOT/OIG nexus? There was no DOT money suspected in the fraud, no DOT employees, no kickbacks or collusion suspected. Once again, the DOT/OIG mandate is to audit and ensure that the modal agencies, i.e., FAA, follow their mandate to investigate violations of FAA regulations.

You will also be provided testimony about the DOT/OIG's priorities, which include falsified records, fraudulent pilot and mechanics certificates, fraudulent aircraft parts, etc. These are all crimes referenced in Title 49 USC, 106(g), the direct responsibility of the FAA Administrator (refer to footnote 1). This leads to the question of resources. Other than the numbers I previously provided, I can not provide any additional details surrounding resources available nationwide. However, prior to the illegal transfer in March 2001, in the Northwest Mountain region we completed our mandated responsibilities with a great amount of success. And yet, the FAA chose to discontinue utilizing these experienced agents.

I submit that this monumental effort for the Administrator and Secretary to transfer one of the most important mandates incumbent upon the FAA was an attempt to eliminate the Agent's ability to accrue Law Enforcement Officer (LEO) enhanced retirement, as well as Law Enforcement Availability Pay (LEAP). In keeping with the basic legal understanding that a law is more powerful and enforceable than an agency Order or Directive, I would like to offer the subcommittee the following information as a brief explanation as to why this transfer occurred. I believe it was nothing more than a money-driven decision. The FAA retained special agents as criminal investigators since the FAA Act of 1958, but had always denied them LEO retirement and LEAP benefits.

In 1999, after approximately 40 years of having criminal investigators, an agent from my office in Seattle won his entitlement for LEO retirement through a Right of Action with the Merit Systems Protections Board. Eight more FAA agents then followed with their own suits for their enhanced retirement benefits. In January 2001, the FAA signed a settlement agreement with these agents acknowledging their work as criminal investigators and LEO's.

In response, and what amounted to nothing more than a pure act of reprisal, the mandated investigative responsibilities were transferred in March 2001 and the FAA special agents were stripped of all criminal investigative authority and prevented from completing their enhanced retirement. This transfer and removal was completed within 16 months of the first agent winning his Right of Action. Keep in mind that the Secretary of Transportation is prohibited from transferring duties without a reorganization plan submitted to congress.⁶ This was ignored and a revised Order was quickly drafted, which became known as DOT Order 8000.8. In section 5, of this order, it states, "Except as provided below, as authorized by the IG Act . . . , OIG is the only organization in DOT that shall employ criminal investigators (GS-1811s) or perform criminal investigative functions . . ." The two exceptions made were the Coast Guard Investigative Service and the Odometer Fraud Program from the Department of Highways. However, it made no exception for the only other existing criminal investigators in the DOT, the FAA Criminal Investigators. I ask, when did a DOT Order become so powerful as to override existing law?

In conclusion I reiterate it is my belief that the Administrator and Secretary conspired to circumvent federal law.⁷ This egregious action has rendered the FAA powerless to investigate acts of criminal fraud as it applies to Falsified Airman Medical Certificate Applications. I submit that such action has done nothing more than weaken the ability to investigate aviation safety and that the flying public is being cheated. The resources are still available to the FAA if they choose to use them. In addition, if one simply ignores the fact that DOT/OIG has no statutory authority for the violation of FAA regulations, its record of sporadic interest in such matters since 2001 is equally egregious. Whether I, or my previous coworkers, believe that the DOT/OIG lacks the authority to investigate crimes involving program operating functions is secondary to the fact that the FAA Administrator, and therefore the FAA Security Division, is remiss for not performing investigative duties mandated by law.

I strongly urge this subcommittee to insist on immediate corrective action. I assure you in the absence of such action, many aviation safety issues will not be addressed properly and could make for a needlessly dangerous situation in the future.

I would be more than happy to speak to anyone in person or to provide further testimony.

(Electronically Transmitted)

James R. Vanderpool, ANM-700
Northwest Mountain Division Manager (Retired)
A Concerned Citizen

⁶ **Section 316(e) FAA Act of 1958:** No power, function, or duty of the Administrator of the FAA shall be assigned or transferred to any other Federal Department or agency.

⁷ **Title 49 USC, Section 322 (b):** . . . However, the duties and powers specified in sections 103(c)(1), 104(c)(1) and **106(g)(1)** of this title may not be delegated to an officer or employee outside the Administration concerned